2 THE FACES OF MOOD DISORDER

The Mind lives on the Heart
Like any Parasite—
If that is full of Meat
The Mind is fat.

But if the Heart omit
Emaciate the Wit—
The Aliment of it
So absolute

—Emily Dickinson, c. 1876

Mood disorders

What we now call depression has been recognized since the beginning of clinical description. It was described by Hippocrates of Cos in the 4th century BC, and was known from late antiquity virtually to the present as 'melancholia'. Originally, as the name suggests, it was thought to stem from an excess of 'black bile' (one of the four 'humours' supposed to make up the human body—the others are blood, phlegm and yellow bile). The relation between mania and depression was also recognized, and the concept of bipolar illness, in a descriptive framework not unlike the modern one, has been current since the 1st century AD, though it went out of fashion, at least in America, for the first half of the 20th century.[1]

How do you know if you're depressed? Or manic? To those who are as some of us like to say 'members of the Club' this question sounds as fatuous as 'How do you know if you have diarrhoea?' You look at the empirical signs, that's all. But far more people can recognise diarrhoea than can recognise depression, and often the seriously depressed may walk around for ages (or forever) without knowing what is wrong with them, or indeed if anything really is, if it is not just the case that life is like that. This holds to a lesser degree for mania and hypomania: these are harder to recognise(and more often denied by people going through them than depression), but once you know they are obvious.

Somewhat helpfully, the Internet is infested with nearly identical little quizzes that purport to tell you if you are depressed or manic, and usually give you a numerical score and a brief assessment; if your numbers are at the wrong end they tell you to see a mental health professional (often 'urgently'). These quizzes are mostly not bad; I have looked at all I can find, and seen little that is eccentric or misleading. If you wonder whether you are depressed (or manic for that matter), it is not a bad idea to take one, just to get an idea of what to look for. And such quizzes, as a form of elementary education, can be of assistance to friends and family: if you

[1] See the historical surveys in Goodwin & Jamison 1990: chapter 3, Solomon 2002: chapter VIII.

think X might be depressed or manic, this is a simple way to get some elementary information. Just take the quiz as it were 'for' X giving what you think would be his answers. The comments on your score will tell you perhaps that you are 'moderately depressed', or 'severely manic', and will stress that this is not a diagnosis but an indicator, and if you score at all manic or depressed you should 'see a health professional'.[2]

The terms 'mood disorder' and 'affective disorder/illness' tend to be used interchangeably, though some psychiatrists have tried to make distinctions. So McHugh & Slavney (1998: 72) take 'affect' as the more general category, and 'mood' as more specific.

> *Affect* is a broad term encompassing moods, emotions, motivations, and such feelings as pleasure, confidence, depression, and discouragement. Attempts to replace it with other words are usually unsatisfactory. *Mood* describes a relatively persistent, dominating affect; *emotions* are more fleeting affective events; and *feeling* is a word confused with bodily sensation. The term *affect* is needed because it encompasses this whole sphere of psychic life.

This unfortunately does not quite match non-technical usage; *mood*, *moodswing*, *moody*, *moodiness*, etc. are everyday terms, and not only do not necessarily connote, but may be opposed to, 'relatively persistent'. The background to technical usage is always ordinary speech; echoes remain, no matter how much professionals try to purge their language of the vernacular taint. 'Affective' may be more 'technical', but 'mood' is two syllables shorter (not a trivial advantage), and so commonly used in psychiatry that I have no hesitation keeping it. The colloquial sense of shifting and non-persistence is worth retaining anyhow, since at least some disorders are characterised precisely not by persistence but by evanescence and instability. Others of course are characterised by persistence, but 'mood' will do for both.

In terms of what the victim feels or outsiders observe, 'moods' in the psychiatric sense are relatively long-lasting or recurrent, highly enhanced, 'abnormal' (even 'crazy') versions of certain commonplace emotional states. The psychiatric concept of mood can be best understood by analogy with everyday usage: one is in a good or a bad mood, and moods include contentment, happiness, euphoria, sadness, anxiety, irritability, anger, fear.

'Disorder' means long-term dysregulation. Not only are particular moods so intense that they appear 'inappropriate' to observers, or irrelevant to the situation at hand; the deviations from 'normality' may last longer (but not necessarily: intensity rather than duration may signal the abnormality). The *DSM-IV* (*Diagnostic and statistical manual of mental disorders*, 1994, which is supposed to be the bible of psychiatric diagnosis) defines a major depressive episode as a depressed state lasting at least two weeks.[3] If you are 'normal', imagine being profoundly

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[2] Just Google 'depression quiz' or 'mania quiz'. Most of these are rather crude, but they may be at least indicative.

[3] This is a faulty definition: would some of the states described in chapter 1 not count as 'major depression' if they lasted only 11 days, or even 2? Duration is a less useful criterion than the *DSM* makes it out to be. I will often use their classifications, since they are fairly well known and count as part of a 'formal diagnosis', but I

depressed for two weeks, and you can get some idea. Of course everybody has mood changes—spells of irritability, anger, sadness, euphoria. Mood disorder proper is distinct from these everyday shifts, as hayfever is from a few sneezes. It has also been claimed to be distinct from relatively short-term responses to what the jargon calls 'life events', like losing a parent or partner or a beloved pet, being made redundant, finding out you have cancer. The relation between the mood-alterations provoked by these occurrences and long-term pathologies seems self-evident, but some psychiatrists distinguish between 'reactive' depression provoked by a psychic assault like the above and 'endogenous' depression—apparently unprovoked, coming from inside. There is no empirical support for this distinction,[4] and mainstream psychiatry treats both the same way. The difference is like that between arthritis brought on by injury and arthritis brought on by years: anti-inflammatories will help both, and clinically they may be identical. If there is any distinction at all, it would seem to be that strictly 'traumatic' or 'reactive' episodes of depression, with no underlying depressive illness, may be self-limiting and non-recurring. But they can look and feel just the same, and will respond to the same treatment as chronic or recurrent depression.[5]

The mood-changes experienced by people with no psychiatric illness can be ranked along scales like depressed-to-elated, happy-to-angry, calm-to-anxious, etc. These are often triggered by external experiences (traumas, good luck). They can also reflect internal physiological states, as in the disarrangements of mood that may accompany menstruation (PMS), where the bloodstream's altered hormonal landscape triggers changes in brain chemistry. Or they may just occur with no apparent reason at all (e.g. 'getting up on the wrong side of the bed').

Chapter 1 was not a general (or fully generaliseable) description of depression. It was simply part of the story of one person's experience of a particular kind called 'bipolar disorder', traditionally and I think better 'manic depression'; as distinct from a purely depressive ('unipolar') disorder, where the alternations (if any) are between simple nondepressed and depressed mood. From a classificatory point of view, mood is best thought of not as a collection of discrete states, but rather a *range* or as psychiatrists say 'spectrum' of possible states, with 'centres' that might be ranked along a scale, say from the 'lowest' to the 'highest', and named.

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will take them with a few pinches of salt. For research purposes they are useful; clinically there is room for doubt. I would rather trust the intuitions of an experienced psychiatrist than the rigid and forrmulaic definitions of the *DSM*.. They are coarse and according to many psychiatrists I have talked to not that helpful. They tell me their patients just don't appear in there, but are richer and more complex.

[4] See Maj 2008. Some also distinguish between 'psychological' depression and depression brought on by 'biological' causes. The arguments in chapters 3-5 will show that this is meaningless. Mind and mood are as 'biological' as digestion and sex.

[5] This raises the possibility (which some may find abhorrent) that even grief and bereavement may be treated as medical conditions. My own experience suggests they can and should. Having suffered both depression and bereavement I am not entirely sure I could even tell the difference except for some of what you th ink about, and antidepressants help relieve both. See Kendler *et al.* 2008. For an interesting model showing grief and major depression as regions on a 'spectrum' see Pies 2008.

Names and definitions tend to make us feel secure; this can sometimes be dangerous, or at best unproductive and circular (see the final section of this chapter). But if we do not take names too seriously, we can use them safely as rough pointers. This is about as good as words get. So I have not defined 'mood' in a respectable scientific way. Let us just say that *mood is the brain's interpretation in the language of psychology of certain aspects of its own electrochemical and structural landscape*.

But even if mood itself is an elusive notion, a sensible ranking—say from the worst possible mania to the worst possible depression—is not only possible but useful. One good model is the Fieve Mood Scale (Fieve 1997). This is designed for self-rating rather than medical diagnosis, but includes most of the basic signs and terminology given in the standard psychiatric sources. This scale conveniently takes zero as notional 'normal' mood, and assigns positive numbers to the 'up' states from normal to manic, and negative ones in a parallel way for 'down' states from normal to depressed. Depressed states are on the negative end of the scale, manic-depressives jump from positive to negative and back or vice versa, and manic states are at the positive end.[6] This gives a scalar representation of the mood spectrum, and makes explicit the problematic boundaries separating the 'normal', the merely uncomfortable, and the horrible and dangerous. Here is a modified version of the scale, listing typical signs: [7]

The Fieve Mood Scale (Modified)

+5. *Manic Psychosis*.[8] Incoherent, violent or paranoid, delusions and/or hallucinations; high risk-taking, some depressive features.

+4. *Mania*. Elated, hyperactive, can't stop talking, little need for sleep, distractable, racing uncontrolled thoughts; irritability and anger, rage when provoked, poor judgement, sexual and financial risk-taking.

+3. *Hypomania*. Energetic, expansive, full of ideas, speech 'pressured', rapid, punning and odd associations common; enhanced libido, sexual and financial risk-taking but less than in mania,

[6] 'Mixed states' also commonly occur, which have both manic and depressive components; I will return to them later as they are a subtle and complex matter.

[7] See Fieve 1997: Appendix A for the original version. I have added a number of criteria that in my experience are typical of the named and numbered states. The Fieve-Dunner mood scale (Fieve, 228) is similar, but does not name the states in the standard way and is more clinically oriented. There are many other scales and inventories and questionnaires that psychiatrists use in establishing patient profiles and the state of a mood disorder, but the one I give here seems most useful for this book, and introduces the main terminology.

[8] 'Psychosis' implies the presence of hallucinations or delusions, or general disconnection from what is sometimes called 'consensual reality'. A hallucination is a false or erroneous sensory experience; a delusion is a false belief. Joan of Arc's 'voices' were hallucinations; her conviction that she was divinely called to be the saviour of France was a delusion

compromised judgement, irritability, less than normal need for sleep. Overall less intense than mania proper, and patient can still function relatively normally at work and socially, often better and more creatively than when not hypomanic.

+2. *Hyperthymia*. Energetic, productive, successful, sociable, sometimes irritable; a 'high', but neither pathological nor distressing.

+1. Top of normal. Just a little better than usual.

0. *Normal*. No depression, mania, compromised social or professional function, no explicit awareness of mood, or evidence of anything unusual to outsiders.

-1. Bottom of normal.

-2. *Hypothymia*. Low-keyed, perhaps withdrawn, functioning normally otherwise; efficient, conscientious, perhaps obsessive or compulsive behaviours, perfectionism. In Fieve's words, 'doing okay'.

-3. *Dysthymia*. Mildly depressed, loss of interest or pleasure in ordinary activities ('anhedonia'), loss of energy; poor self-image; disturbed eating or sleeping; lowered libido; general pessimism.

-4. *Major Depression*. Depressed mood, anhedonia, disturbed eating and/or sleep patterns; hopelessness and feelings of despair and unfocussed psychic pain, guilt, uselessness, fraudulence;[9] quasi-paranoid feelings of having injured people when one has done nothing at all; difficulty concentrating or making decisions; uncontrolled weeping; low energy, sometimes to the point of stupor; suicidal feelings; anxiety or panic; lowered or absent libido.

-5. *Delusional Psychotic Depression*. Delusions and/or hallucinations in addition to symptoms of major depression; total withdrawal or extreme agitation.

Not all the signs associated with a given spectrum region may be present at the same time; e.g. there may not be depressive features in a manic psychotic state, there may not be financial or sexual risk-taking in hypomania. These are catch-all but not irresponsible categories .They provide good general pictures of the states associated with the terminology, and I will use the terms for reference throughout. States +1, +2 and -1, -2 are so close to normal variations of mood

[9] These feelings of being wicked or fraudulent appear to be episodes of delusional thinking driven by underlying mood; they are called 'secondary delusions'. In chapter 1 I describe my feelings of fraudulence and being 'finished'; a depressed friend of mine wrote me and told me that she was 'a piece of shit, a monster'; another wrote 'I'm a fucking wreck, used goods, broken, are you tired of me'.

that they do not seem very useful categories. Certainly very few clinicians would try and treat them.

Fieve calls both +5 and -5 ‘medical emergencies’; patients typically require hospitalization, voluntarily or (perhaps more often) not.[10] Suicide is certainly possible in both, though not exclusively: suicides or suicidal attempts may occur in moments of extreme clarity and relatively elevated or neutral mood after a major up- or downswing, as a kind of prophylactic against further occurrences (‘rational suicide’),or just because the easing of the depression restores enough energy for the sufferer to act.

Useful as the scale is, like any human classification it is imperfect. It seems to have an excessive numerical precision, but this can be bypassed by remembering that it is really a spectrum or cline, and there are no sharp ‘boundaries’. Assigning an absolute value like ‘+4’ to a mood-state is a pseudo-quantitative convention, not the recognition of a piece of ‘reality’. ‘A state of +4’ is not the same kind of object as a lump in a breast. Numbering can also be a bit of a cheat in more subtle cases, rather like trying to decide whether a picture is ‘real art’ or ‘merely illustration’; the real world is rarely unequivocal. The scale may also be over-subtle (at least for a lay victim); my own experience suggests that while +5 and -5 are pretty clear, the areas on both scales clustering around 3-4 are a fudge or continuum, and one may be vacillatingly depressed or hypomanic for a long time, over a range appropriately conceived as a kind of ‘average’ of these states. I would be inclined to view +3 as ‘mild hypomania’, rather than giving it a special name and number, and the dysthymia/depression boundary is obscure and shifty. In my experience both ‘hypothymia’ and ‘dysthymia’ could characterise a remission in an episode of major depression, or a prelude to one. Or, to capture the inner feeling of these states in a very personal but I think accurate way, dysthymia is a deep sadness or blankness or inertia you can live with, while major depression is that plus overwhelming pain you cannot live with (but have to most of the time).

The normal usage of most victims[11] of mood disorders (which counts, since we tend to talk about ourselves a lot), classifies more coarsely; so do some psychiatrists. Anything from -3 down is ‘depressed’, and anything from +3 up is ‘manic’; the space in between seems to me to cover the usual mood-range of the undisordered. Except when I am referring to formal diagnostic criteria I will use the terms in this looser way.

Applying this scale to myself, I am somewhere between hypothymic and dysthymic a good deal of the time, but can work and function socially. When I can’t, I have crossed over to the dysthymia/major depression borderline. But my work and social performance (as writer,

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[10] Whether the risk of suicide is *always* an ‘emergency’ in the sense that it entitles others to take your life into their hands is a complex question: perhaps to most people the answer is self-evident, but others (mainly the potentially suicidal?) may find it difficult and equivocal. See chapter 8.

[11] I use the word ‘victim’ deliberately; I do not like the kind of politically correct language that characterises anybody who lives through a lethal disease as a ‘survivor’. That is too optimistic for us, and uninformative: if we are still alive of course we are survivors, but that does not give us any moral *cachet* or touch of heroism. We are victims or sufferers or casualties; that is the kind of language that seems appropriate.

lecturer, raconteur, drinking companion) in those states is routine, to me at least often boring. It is only when I reach the higher positive numbers that I really get interesting ideas, and begin to think and talk and write freely and creatively (to some observers crazily, to the more charitable, eccentrically). As I move a bit higher, though, there may be danger signs like silly lapses of judgement, suggesting a shift too high toward manic; it is in these states that I have to be very careful in the presence of attractive women, and try to control the urge to nonstop, often offensive talking. In other words, I seem to be at my best—for the purposes most important to me—when I am unstable and verging on or just over the pathological side of the positive. At times I go over the top, and then can become dysfunctional. So far I do not think I have ever had a true full-blown manic psychosis, but there is still time. I do have a tendency to hallucinate, but I seem so far always to recognise hallucinations for what they are, and not attribute outside-world 'reality' to them; I may have come closer to psychotic depression, judging from the episodes of paranoia described in chapter 1. I have also now begun to have frequent non-euphoric 'mixed' hypomanias, in which I am unhappy and dark but energised and creative; I will return below to this kind of quite common mood state, which a purely linear scale cannot represent.

Types of Mood Disorder: The *DSM* model

Not every depressive *episode* prompts the diagnosis 'a case of depressive illness'. The physical-illness parallel shows up some interesting properties of psychiatric diagnosis as well. It is not that the latter is so different that it requires totally different methods; but rather that it is extremely subtle and complicated, and we know less about the compromised organ—the brain—than most others. And many standard diagnostic techniques, like blood-work and scans, are simply not very helpful, because we do not yet know precisely what to look for.[12]

Say a patient comes to the doctor in an obvious state of severe depression: lowered mood, feelings of guilt and worthlessness, inability to concentrate or to enjoy anything, suicidal impulses. It would seem that strictly speaking, depressive disorder proper cannot be diagnosed on this evidence alone, though the *state* certainly looks depressive. Certain other information is needed: how long has the patient been like this? Is this the first episode? Are there any likely immediate chemical causes, like alcohol, cocaine or amphetamine use? Is the patient taking opiates or tranquillisers? Are there signs of reduced thyroid function? Many conditions that are not depression proper can mimic it: psychoactive drugs and endocrine disorders can have a significant effect on mood, as can many cancers.

So the doctor—ideally—would be interested not only in the current episode, but other aspects of the patient's history (including family history) and present life, habits and general

[12] There are now intriguing developments in brain-imaging, showing metabolic and anatomical correlates to depression, and some interesting biochemical and immunological indicators. These are not yet clinically useful, though they do deepen our understanding of the condition. See chapter 4 for discussion.

health. Except in cases of desperate misery where it would be smarter to treat first and wait for the lab results, it would seem to be counterproductive to start immediately with antidepressants when the primary problem is a thyroid disorder. But we do not live in an ideal world with limitless time for taking histories and limitless money for doctors' time, and this is not the way it usually happens. Certainly not with GPs, who are the usual first resort. There isn't the time, and these are not the protocols medical students learn, Nobody thought of looking at my thyroid functions till over a decade into my full-blown disease. Experienced doctors just saw mood disorder and treated it.[13] And they were right and I am not chastising them.

So the standard formal diagnosis of mood disorders is based on a rather mechanical checklist, which generates diagnoses. The doctor recognises symptom-clusters or 'episodes', and then on the basis of their time-scales, degree if any of cycling, presence of psychosis, etc. groups the episodes into a 'disorder'. So we begin with a classification of mood *episodes,* which'serve as the building blocks for the disorder diagnoses'. There are three main types:[14]

Major Depressive Episode: 'Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure'. The symptoms are: (1) 'depressed mood most of the day, nearly every day'; (2) 'markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day'; (3) 'significant weight loss when not dieting or weight gain [...] or decrease or increase in appetite nearly every day'; (4) 'insomnia or hypersomnia [excessive sleep] nearly every day'; (5) psychomotor agitation or retardation [speed-change in thinking and/or movement] nearly every day'; (6) 'fatigue or loss of energy nearly every day'; (7) 'feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day'. (8) 'diminished ability to think or concentrate [...] nearly every day'; (9) 'recurrent thoughts of death [...], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan'. On my first visit to the doctor, only categories (3) and (5) were missing, so I was quite easy to identify, with a good seven out of nine, two above the minmum.[15]

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[13]It turned out that my thyroid was not a major problem, but that is not the point.

[14] Any unattributed quotations are from *Diagnostic criteria from DSM-IV* 161-197. This is a condensed guide to the full volume, but will serve here. As with the Fieve scale above, I have partly quoted and partly paraphrased and condensed. Some readers may be disturbed by the plethora of apparently subjective and judgmental terms like 'excessive' or 'inappropriate'. Assessment of these requires diagnostic tact and sensitivity; the purpose is not to set up rigid 'norms' for human behaviour, but rather to define these as polar notions, adjusted for the personality of the patient. Not all doctors are good at this, and the less well the doctor knows the patient (and the less sensitive or more rushed the doctor is), the greater the danger of taking symptoms the patient has adjusted to pretty well as pathological. The criteria are or should be simply pointers for the diagnostician, not absolutes: there are degrees of dysfunction, and the idea is not (at least in original intention) to promote a *Brave New World* or *1984* imposed 'normality'.

[15]The fact that I felt the need to write this sentence suggests on reflection that there may be a fundamental

Manic episode: A 'distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)'.[16] At least three of the following symptoms must have persisted (a fourth is needed if the mood is 'only irritable'): (1) 'inflated self-esteem or grandiosity'; (2) markedly decreased need for sleep; (3) unusual talkativeness or 'pressure to keep talking'; (4) 'flight of ideas or subjective experience that thoughts are racing'; (5) 'distractibility'; (6) increased 'goal-directed activity' (social or sexual), psychomotor agitation; (7) 'excessive involvement in pleasurable activities that have a high potential for painful consequences'.

Mixed episode: The criteria for both major depressive and manic episodes (except for duration) are met 'nearly every day during at least a 1-week period'. As with the two others, the disturbance is severe enough to make the patient socially or occupationally dysfunctional, or to necessitate hospitalization, or has psychotic features. These episodes raise serious questions of diagnosis and theory. They may be described by patients and doctors as 'black manias' or 'agitated depressions'.Many psychiatrists are unhappy with the *DSM* definition; it is unsubtle and does not match the kind of mixtures one actually finds (e.g. 'black hypomanias', where the requirement that genuine mania be present excludes one major type of bipolar disorder: so-called Bipolar II, which does not allow for full mania except under special circumstances: see below.) In the most recent thinking, the central property of mixed states is that 'depressed mood predominates but activation and agitation are present' (Schneck 2009: 127). This is less restrictive, and encompasses a much richer range of patients, what the doctor really sees.

Under the *DSM* definition my mixed states, which are commoner nowadays than any other kind, would not be so classified—though that is what my very experienced psychiatrist calls them—because they are 'merely' hypomanic and I can work and socialise during them. But they are undoubtedly agitated, energised, often creative and have depressive affect. So what else could they be but 'mixed'?

These are the three most extreme and disabling episode types, as it were the negative and positive poles of the Fieve scale (or a mixture). The in-between states are treated by the *DSM-IV* in the appropriate manner: thus a *hypomanic* episode is rather like a weaker version of a manic one, but has to persist only 4 days, 'is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic', is not severe enough to require hospitalization, does not cause social or occupational dysfunction, and there is no psychosis. As mentioned above, however, there is no provision for a 'hypo-mixed' state, which is needed.

The *DSM* specifications for duration have been criticized by many clinicians. In

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silliness to the numerical criteria. Or that I am scientifically shallow, of course.

[16] This is a rather odd criterion, since different doctors might hospitalise under different conditions, some might be more reluctant than others, etc. A doctor's contingent choice hardly counts as a rational diagnostic sign.

particular, the mania and hypomania specifier ‘most of the day, nearly every day’. This simply does not fit with the fact that manic episodes often only last a few hours rather than days. Nor is it consistent with the frequent high function of the hypomanic; at least I am capable of doing difficult and careful academic work during a hypomania (either euphoric or black—and so are others I know). And I have certainly had undoubted major depressive and hypomanic episodes that lasted no longer than a couple of hours or at most a day or so.

The Disorders

The episodes are organized into larger sequences called ‘disorders’. These fall into a number of types, depending on severity, recurrence, persistence and degree of cycling between states. They can be further characterized as chronic or not, having catatonic features (immobility or stupor), or melancholic ones (lack of reactivity, anorexia). As with other disorders, there is a set of ‘severity/psychotic/remission specifiers’, which define the status of the disease at a particular point. For instance, the severity scale runs from Mild to Moderate to Severe; the psychotic scale is two-valued, Without Psychotic Features and With, and the remission scale includes Partial and Full Remission. This provides a fair-sized set of diagnostic criteria.. Whether the average GP or even psychiatrist uses the *DSM* criteria formally when diagnosing and treating depression is probably answerable only by taking a poll. I would think that GPs sensitive to and interested in their patients’ psychic states, and who work in systems liberal or well enough financed to allow them to talk to them for more than five minutes, know the criteria and use them at least informally. The story may be different with psychiatrists, who typically have more time for assessment and more specialised training and experience. But clinically (or even for highly experienced patients with no special training) one generally ‘just knows’ what depression looks like. I and many of my depressed friends have often sent other, undiagnosed friends to doctors, and none of us seems to have been wrong yet.

The whole classificatory system takes up nearly 30 pages just in the *DSM* digest; I will discuss only the major and least subtle types. Anyone interested in the details should go to the full *DSM-IV,* read some psychiatry textbooks, and compare the *DSM* system with that in the *International Classification of Diseases* (*ICD-10*).[17] I now assume all the *DSM* hedges: symptoms are not better accounted for by drugs or other disorders, either physical in the conventional sense or psychiatric.[18]

[17] For a detailed summary and study of the *ICD* criteria, see Sartorius 1991.

[18] The exclusion of other psychiatric disorders is important, as both manic and depressive episodes can occur in schizophrenia and other psychotic conditions. Some neurological disorders that are ‘physical’ in the crude sense, e.g. some forms of epilepsy, Parkinsonism, and various senile dementias may also present with affective symptoms But these can often be treated successfully as if they were ‘ordinary’ mood disorders..

The Unipolar Disorders

(i) Major Depressive Disorder, Single Episode: As the name suggests, this is simply defined by a major depressive episode not better accounted for by other disorders or stressors, and there has never been a manic episode.

(ii) Major Depressive Disorder, Recurrent: There have been two or more separate major depressive episodes, and no manic episodes—though manic- or hypomanic-like episodes may be 'allowed' if they are the result of drugs: either extracurricular indulgences of the patient, or prescribed. Some antidepressants for instance can trigger (hypo)manic episodes (so-called 'manic switching'), though this is commoner in the bipolar disorders discussed below.

(iii) Dysthymic Disorder:[19] A rather milder disorder, like major depression but showing fewer of the specifying symptoms. The basic characterization is 'depressed mood for most of the day, for more days than not', but it requires only a minimum of two symptoms out of the group of (1) poor appetite or overeating, (2) insomnia or hypersomnia, (3) low energy or fatigue, (4) low self-esteem, (5) poor concentration or difficulty making decisions, and (6) feelings of hopelessness. There must not have been any major depressive episodes, and a proper narrative reconstruction ought to distinguish it from Major Depression in partial remission .

There are also other depressive disorders, informatively called 'Depressive Disorder Not Otherwise Specified': these include premenstrual dysphoric disorder (the famous PMS), minor depressive disorder, postpsychotic depression from schizophrenia, and finally 'situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced'. The last one, like dysthymia, indicates the importance of sensitive and intelligent history-taking and good communication between doctor and patient. It is not that the 'real name' of the disease matters because it is some kind of magical talisman (though many patients—and doctors—feel happier with 'officially named' diseases); rather that a sound judgement of severity and type of illness has implications for treatment, which in turn has implications for prognosis. The involuted and almost painful detail of the *DSM*'s schematics may just serve a useful purpose: if properly applied it can help prevent putting sticking-plasters on gunshot wounds or stitching mosquito bites.

The Bipolar (Manic-Depressive) Disorders

This complex group is defined by the alternation of opposed mood states, at roughly opposite ends

[19] Dysthymia and certain other *DSM* 'disorders' might be better interpreted as signs of predisposing 'temperaments' which increase vulnerability to disorders, or *formes frustes* 'fragmentary or not fully realised forms' of more serious disorders: this position is taken convincingly for dysthymia in Kramer 1994.

of the scale. There are two conventional types, called Bipolar I and Bipolar II. I am not fully convinced that this distinction is all that useful; but the official difference is that in Bipolar I there are fewer episodes, with longer interludes, perhaps a long history of major depression with only one manic episode. Bipolar II is defined as 'recurrent major depressive episodes with hypomanic episodes', but without true manias, thus the less serious of the two. This would appear to leave a common kind of bipolar disorder like mine—with both major depressive and occasional manic episodes as well as hypomanias and mixed episodes—in a classificatory limbo. But there is the specifier 'with rapid cycling', which involves 'at least four episodes of a mood disturbance in the previous 12 months that meet criteria for a Major Depressive, Manic, Mixed, or Hypomanic Episode'.[20] Since this can be applied to either Bipolar I or Bipolar II, I can now name myself, if with an amateur's uncertainty: I appear to be a fully paid-up Bipolar II with rapid cycling. There is a simpler and more elegant definition of Bipolar II in Jamison (1993: 74): 'major depressive illness with a history of hypomania'. This really says all that has to be said.

Ronald Fieve (1997) has suggested an extra classification, in which the 'abnormal' up episodes are actually the best part of the person's life, where he is most creative, original, and functional. This enhancement of function, even if pathological, defines the person's role in life or professional competence. He calls this Bipolar II_B, and gives it the epithet 'the beneficial illness'.[21]Among his examples of apparent victims (or beneficiaries) of this disorder are a number of extremely gifted and famous people: Handel, Rossini, van Gogh, Hemingway, Abraham Lincoln, Theodore Roosevelt, Winston Churchill, and Ted Turner (of CNN). Many other major figures have been retrodiagnosed (correctly, I think) by various authors as at least bipolar if not necessarily $II_{B:}$ Mozart, Schumann, Hugo Wolf, Keats, Shelley, Byron, Gerard Manley Hopkins, T.E. Lawrence, Virginia Woolf, Robert Lowell, and Sylvia Plath.[22] Whether a new classification is needed is arguable; but the idea is not only appealing but surely right. Many manic-depressives (I am one) feel truly alive only in their elevated (or mixed hypomanic) states, and essentially dysfunctional (though to different degrees and in quite different ways) both when 'normal' and when depressed. This raises the possibility that it could be a good thing for not all aspects of a bipolar (or for that matter unipolar) illness to be 'cured' or even treated at all; this is an important and neglected issue, which I will return to in chapter 5.

. Anxiety frequently co-occurs with either (hypo)manic or depressive episodes. This may reflect a comorbid Generalized Anxiety Disorder; or the recurrent anxiety may be, as many

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[20]This seems rather conservative for the adjective 'rapid': I can do more than four in a *day*.

[21] I was intrigued by this idea since it seems in general to fit my own condition: though the beneficial effects of my hypomanias can slip off into instability and disruption at times. Still, I wouldn't trade them for all the lithium in the world, so maybe I have a *B* attached to my Bipolar Disorder a good deal of the time, with occasional (and unpredictable) lapses.

[22]The classic study of the relationship between creativity and bipolar disorder is Kay Jamison's *Touched with fire* (1993). This is a moving, exquisitely written and formidably well researched study, and nobody with an interest in either mind or art should miss it.

psychiatrists (including mine) think, a symptom of the underlying depression. It is interesting that many antidepressants are also anxiolytic, and many clinicians choose to treat anxiety with them, even when there is no obvious depression present (see Carey *et al*. 2008). Depression is a complex disease (or complex of diseases), and this is made worse by its frequent comorbidity with other disorders. (I have two friends who are both schizophrenic and depressed, one unipolar and the other bipolar.)Unfortunately a patient does not have to have just one disorder at a time, or have to be typical. It is of course nice to be typical, even typically mad, because it makes you easier to treat: doctors cut their teeth on the typical.

A most ingenious paradox: polarity, cyclicity and mixed states

I noted earlier that many psychiatrists find the *DSM* categories problematic. They lack specificity and/or subtlety, are often apparently arbitrary, are poor predictors of the course of illness, and provide no indications for treatment. But there are more serious conceptual difficulties. The characterization of mood on the Fieve scale is strictly linear: either you are on one end or on the other. The *DSM* criteria are similar: unipolar and bipolar disorder are distinguished, and mania and depression are opposite ends of a single scale. Yet as we saw, the *DSM*, self-contradictorily, also recognises an important category of 'mixed states'. The issue is geometrical to begin with: if 'up' and 'down' are polar opposites on one scale, how can you have both simultaneously? Maybe there is something wrong with the idea of a purely linear scale?

In their classic book on bipolar disorder, Goodwin & Jamison (1990) suggest a radical revision of the unipolar/bipolar relation. They distinguish sharply between the conceptual categories 'polarity' (the opposition between the top and bottom of a mood scale) and 'cyclicity' or recurrence. They also suggest that depression and (hypo)mania may be best conceived not as points on the same linear scale, but as two separate but related spectra; this allows an individual to be positioned independently on both. Hence mixed states are no longer paradoxical but expected, falling out naturally from the categories provided by the theory. As they say (1990:78), 'it is best to consider the depressive spectrum and the manic spectrum as independent and interacting in a variety of combinations and permutations'. Polarity then is not purely scalar, as on the Fieve or *DSM* interpretations, but much more complex and subtle. This does not by any means make linear scales useless; but it does limit their applicability and provides a much more densely textured and intricate picture of the disorder. The problem had in fact been noted by Emil Kraepelin (1921), in the first major work to define bipolar illness as a distinct clinical entity; but like many insights of this extraordinary psychiatric observer and theorist it took a long time to be fully appreciated (as it still is not in the *DSM* framework):

> We observe also clinical "mixed forms," in which the phenomena of mania and melancholia are combined [...] so that states arise, which indeed are composed of the same morbid symptoms as these, but cannot without coercion be classified either with the one or with the other [...] Further, it was seen that the mixed states, even when they appeared not as interpolations but as independent attacks, behaved with regard to their course and issue quite similarly to the usual forms, and lastly, that they might in the same morbid course

simply take the place of the other attacks especially after a somewhat long duration of the malady.[23]

Goodwin & Jamison pick up Kraepelin's last point, and note some interesting properties of certain unipolar disorders that make them much less distinct from bipolar disorders than the usual classifications claim. This is his observation that for some patients mixed states may play the same 'role' (in terms of occupying 'slots' for recurrences) as either manic or depressive episodes.[24] The notion of specific recurrence patterns, with localised 'slots' that may be 'occupied' by any one of three episode types, of any degree of intensity, grows naturally from the proposed independence of polarity and cyclicity. That is, there is a 'cycloid' or 'cyclothymic' temperament, whose primary characteristic is simply recurrent moodswings; and this cyclicity may be largely independent of the actual *content* of the moodswings. Indeed, certain unipolar patients appear to show very high frequency of depressive episodes, no manias or hypomanias, have family histories of bipolar disorder, and, most interestingly, respond to lithium in much the same way as bipolar patients. This supports the claim that cyclicity and polarity are independent, and both have to be considered in diagnosis and treatment.[25]

So the unipolar/bipolar distinction in its usual rigid form may not be as helpful as has been thought. If we distinguish carefully between polarity (itself a complex concept) and cyclicity, it is clear that the latter is more a matter of time-course and recurrence than the particular mood(s) involved. In some cases recurrent major depression with 'normal' or 'euthymic' mood as a baseline may be closer to manic depression than to non-recurrent or very infrequently recurrent major depression. And in many bipolar patients most of the 'up' states may be mixed, as seems to have become the case with me in the past year or so.

Mixed states are so common and so complex that suggestions have been made to diagnose in a quite different way from the rather coarse *DSM* criteria, and to recognise a spectrum of bipolar types, including not only pure depression and pure mania, but also mixed depression, mixed hypomania and mixed mania, and utilise a much more subtle range of treatment regimens, including mood stabilisers and antipsychotics in cases where before only antidepressants would have been used (Schneck2009).

So my rather shaky *DSM* characterisation of my state is not the only one: my condition is more complex than they allow, it is recognised in respectable professional literature, and I do not even represent a particularly rare species. Endangered, yes, but only individually: there are still plenty of us around.

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[23] Quoted from Goodwin & Jamison 1990: 54.

[24] Similar ideas had been proposed in the 19th century for episodes of psychosis in epileptics, which were known as 'epileptic equivalents'.

[25] For discussion and references see Goodwin & Jamison 1990: chapter 4, especially 80ff.

Seasonality

Affective episodes are often associated with seasonal changes. For some authorities seasonal mood changes constitute a separate disorder, Seasonal Affective Disorder (SAD); for the *DSM*, seasonality is a 'specifier', i.e. a further diagnostic feature like rapid cycling or presence or absence of psychosis. The journal entries in chapter 1 show a seasonal element in my changes of mood: autumn and early spring depression, later spring and summer hypomania—though neither is fully regular. Most depressives show at least some tendency toward seasonal mood change, and perhaps the majority do not have more episodes of this kind than of the untriggered, season-independent ones, so do not fit the *DSM* criteria for SAD, which require that. So how much use is this specifier, defined so tightly? Perhaps it would be worthwhile to think of restricting the term SAD to those whose disorders are (almost) purely seasonally triggered, and assume that anybody with a recurrent mood disorder is likely to show some seasonality.[26]

Strong mood seasonality is most common in high northern latitudes, where the dark cold winter/bright warm summer opposition is clearest, and appears to diminish toward the equator, as seasonality itself diminishes. The same sort of pattern is probable below the equator (though the research concentrates on the northern hemisphere); in my own case the subequatorial latitude of Cape Town (34°S) is 'Mediterranean', and sufficiently seasonal to provoke episodes at transitions.

Goodwin & Jamison (1990: 243-4) analyse 20 or so studies of the relation of suicide to season, and find that in the northern hemisphere the peak seems to be around May, with a smaller secondary peak in October; the few southern hemisphere studies show a similar pattern, with women more responsive to the autumn peak. They note that the seasonal influence appears to be somewhat reduced in industrialised countries (perhaps because of the high prevalence of artificial lighting and central heating, 'which may insulate patients from risk factors for affective episodes'). One peculiarity in the picture is Iceland, which in a series of detailed studies shows no evidence of seasonality in mood change. Since this is quite unlike what I have observed (anecdotally) in frequent visits to Finland, and what many Finns themselves are highly conscious of, it may be due to some genetic oddity in Iceland's extraordinarily homogeneous and genetically isolated population.[27]

Some non-psychiatric 'clinical' portraits

Half a millennium ago: *the diagnosis of depression as sin*

The faces of mood disorder are not all modern faces. A superb early description of depression

[26] See Whybrow 1987: chapter 5 for a case-history of an almost purely seasonal depressive illness.

[27] Anon. 2000a. The latitude of Rejkavík is about 64°N; that of Helsinki 60°N.

appears not in a medical work, but in a 14th-century treatise on penitence, under the heading of a 'sin'. In the Catholic tradition, there is a special set known as the Seven Deadly Sins; Pride, Anger, Envy, Lust, Avarice, Gluttony, and one usually translated as Sloth. This last is quite different from what that word normally suggests. Though slothful behaviour is involved, the profile of this sin, *Accidia* (or *Acedia*) in Latin, is very like a well-observed description of depressive illness. It also contains as a subtype the worst of all possible transgressions: the Sin Against the Holy Ghost, despair. It is not beyond imagining that some of the moral disgust and stigma with which depression is viewed by so many lay people is at least in part a hangover of this early Catholic tradition, with later Calvinist additions.[28]

At the end of Chaucer's *Canterbury Tales* (c. 1380) comes the *Parson's Tale*. It is not a 'tale' at all, but a long prose homily (technically a penitential manual) on the Seven Deadly Sins. What is interesting for our purposes is the psychological portrait of the person guilty of (or as we would say now, I hope, suffering from) *accidia*. The framework is theological and passionately judgmental, the theological mindset alien (at least to non-Catholics like me); but the description itself is remarkably accurate, and clearly based on sophisticated observation, probably the fruits of a long tradition of sacramental confession and intensive pastoral counselling. I give the relevant passages in the original Middle English, with translations in footnotes.[29]

Accidia is defined this way:

> Thanne is Accidie the angwissch of troubled herte [...] Certes, this is a dampnable synne, for it dooth wrong to Jesu Christ, in as muche as it bynymeth the service that men oghte doon to Christ with diligence [...] But Accidie doth no swich diligence. He dooth alle thyng with anoy, and with wrawnesse, slaknesse, and excusacioun, and with ydelnesse and unlust [...][30]

One of the early consequences is sloth, which is abominable, and can best, in the author's judgement, be treated by breaking the state of inaction and doing things in the world:

> Now comth Slouthe, that wol nat suffre noon hardnesse ne no penaunce. For soothly, Slouthe is so tendre and so delicaat [...] Agayns this roten-herted synne of Accidie and Slouthe sholde men

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[28] Whybrow 1987: chapter 5 has a fine case-study of a contemporary theologian who interprets his own depression as a state of sin. The most detailed historical treatment is probably Jackson 1986. See also the summary of historical evidence from the Greeks to the present in Goodwin & Jamison, chapter 3.

[29] Text from Benson 1987. I have made one or two silent alterations of mistranscriptions. This treatise represents a tradition which would have been familiar to literate Christians of the time. The essential theological psychology goes back to the works of the 4th-century writer John Cassian. I like this particular example because it is in (a form of) English, and particularly vivid.

[30] 'Accidia is the anguish of a troubled heart [...] This is surely a damnable sin, for it does wrong to Jesus Christ, since it takes away the service that men ought to do with diligence to Christ [...] But Accidia does no such diligence. (The man with) Accidia does everything with vexation, and with fretfulness, slackness and excuses, and idly and with lack of pleasure'.

> exercise hemself to doon good werkes, and manly and vertuously cacchen corage wel to doon [...][31]

Sloth appears to be part of a sequence; if you let it go long enough, it leads on to despair:

> Now comth wanhope, that is despeir of the mercy of God, that comth somtyme of to much outrageous sorwe, and somtyme of to muche drede, ymagyning that he hath doon so muche synne that it wol not availlen hym, though he wolde repenten hym and forsake synne [...] this horrible synne is so perilous that he that is despeired, there nys no felonye and no synne that he douteth for to do, as shewed wel by Judas.[32]

This (theological and psychological) despair is accompanied by behavioural anomalies, including sluggishness and hypersomnia:

> Thanne comth the synne that men clepen *tarditas*, as whan a man is laterde or tariynge er he wol turne to God, and certes that is a greet folie. He is lyke to hym that falleth in the dych and wol nat rise ...[33]

> Thanne cometh sompnolence, that is sloggy slombrynge, that maketh a man be hevy and dul in body and in soule [...][34]

From this point, things get worse; the end is complete dysregulation of affect and loss of the will to live:

> Thanne comth a manere cooldnesse, that freseth al the herte of a man [...] thanne wexeth he slough and slombry, and soone wol be wrooth, and soone is enclyned to hate and to envye. Thenne comth the synne of worldly sorwe, swich as is cleped *tristicia*, that sleeth man [...] For certes, swich sorwe werketh to the deeth of the soule and of the body also; for thereof comth that a man is anoyed of his owene lif. Wherfore swich sorwe shorteth ful ofte the lif of man, er that his tyme be come by wey of kynde.[35]

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[31] 'Now comes Sloth, that will allow no tribulation or suffering. For truly, Sloth is so tender and delicate [...] Against this rotten-hearted sin of Accidia and Sloth men should exercise themselves to do good works, and in a manly and virtuous manner acquire the courage to do well [...]'

[32] 'Now comes wanhope, that is despair of God's mercy, that comes sometimes from too much outrageous sorrow, or excessive fear, imagining that he has done so much sin that repentance and forsaking of sin will not avail him [...] This horrible sin is so perilous that he that is in despair is not afraid to commit any felony or sin, as shown by Judas'. (The reference is to Judas' hanging himself in despair after the betrayal of Jesus; the theme of suicide returns shortly.)

[33] 'Then comes the sin that men call *tarditas*, as when a man is delayed or tarries before he will turn to God, and certainly that is a great folly. He is like one that falls in the ditch and will not rise [...]'

[34] 'Then comes somnolence, that is sluggish slumbering, that makes a man heavy and dull in body and soul [...]'.

[35] 'Then comes a kind of coldness, that freezes a man's whole heart [...] then he grows sluggish and sleepy, and soon will be wrathful, and soon is inclined to hate and to envy. Then comes the sin of worldly sorrow, which is called *tristicia*, which slays a man [...] For surely such sorrow conduces to the death of the soul and also of the body; for it makes a man oppressed by his own life. Wherefore such sorrow shortens the life of man, before the

The point of this extensive observation is that major depression and its consequences were well known to the medieval church, but were not interpreted as illness—indeed, there was no framework for such an interpretation.[36] They were sins, but considered expiable (= curable) through complex rituals of confession, contrition and penance in an environment where the sacramental was psychologically real (priest as therapist, rather than today's therapist as priest). But the diagnosis is coherent, and the symptoms grouped together under this one capital sin would now be seen as a syndrome characteristic of a particular mood disorder. This suggests how important the framework in which you view a human condition can be: the concept 'mental disorder' was simply not available in the theological psychology of the late Middle Ages—though there was a sophisticated knowledge of such entities.

Two literary portraits

Sensitive and well-trained doctors will generally be able to recognise depression. But what about ordinary people, the victims of the illness and their relatives and friends? What signs would identify someone who is depressed but might not know it, and suggest that medical attention might be in order? Are there physical postures and appearances, ways of speaking, thinking, patterns of activity (or the lack of it) that mark mood-disordered states? In this section I look at depression from the outside rather than the inside: what does a doctor see when a person with depression presents, and what might any outside observer see or hear?

A talented novelist can create compelling and accurate pictures of psychiatric disorder. For the lay person these may be more informative than clinical descriptions, since they are embedded in often passionate descriptions of whole lives and human interactions. One of the best I know is the depiction of the depressive priest Walter in Gail Godwin's superb novel, *Father Melancholy's daughter* (1991). In these quotations, the narrator is an adult remembering herself as a very bright and precocious little girl of six:

> Daddy got depressed and had "depressions." Sometimes they were just little, temporary ones, brought on by a disarranged day, or an unexpected surfacing of a parishioner's ill will, or somebody criticizing him [...] Or, occasionally, just an item on the evening news would stoke Daddy's melancholy certainty, always burning on its low blue pilot light, that the world was sinking daily to new depths of ignorance and brutality. These short-term flare-ups, or "mini-blues" as Ruth called them, trying to tease him out of them, usually lasted no longer than an hour or two, or maybe overnight. But both she and I worked very hard to forestall them, the way you treat a minor infection before it turns into something worse.
>
> [...]
>
> Daddy's other depressions, the big ones that could last for months, came on suddenly and often for

natural end comes'.

[36] Mania and delusional psychosis on the other hand were generally interpreted not as sin, but as demonic possession, treatable by exorcism. In later periods they came to be identified with witchcraft.

> no apparent reason. He'd just put his head down in his hands at breakfast and murmur, "Ruth, I think it's starting again." And Ruth would say, "Let me call Doc McGruder and get a prescription, before it gets too bad." "No," he'd say, "let's wait. It seems I ought to be able to vanquish this thing myself." [...] "Let's give it another few days," he'd say, his normally rich and rolling voice already gone flat and dull [...] (33-5) [...]
>
> He somehow got his sermons written, only he had to start on them Tuesdays instead of Fridays, and every word he wrote down was written without hope or pleasure, every sentence reexamined and found wanting. "This is all counterfeit," he would announce [...] Then he would sit down in one corner of the breakfast nook and hide his face in his hands [...]
>
> Ruth [...] would go through Daddy's latest sermon while he sat with his face buried, waiting for the worst. But the worst never came. "But this is very good, Walter," she would say. "I don't believe you could write a bad sermon if you tried." "Oh, come on, Ruth. You don't have to flatter me. It's worse than bad. It's fraudulent. I felt nauseated the whole time I was typing it. Disgusted by my own presumption." (36)

Walter calls his depression 'the Black Curtain'. To his six-year old daughter's question about whether the Black Curtain will be coming back he replies:

> "It's not a question of the Black Curtain *coming back*, sweetie. The Black Curtain's always there. It's a place where I *go*."
>
> "But why do you go there? You know you don't enjoy it."
>
> "I certainly don't [...] Oh no, I do not enjoy it [...] why *do* I go there: I'm not sure myself. It's more as if I *wander* there, or get led there [...] and suddenly, before I know it, I'm behind the curtain again and everything is dark. I can remember perfectly well what it was like, back in the world of light and meaning, but, you see, once I'm behind the curtain I can't find my way back. What's worse, I sometimes don't even want to. I don't have the energy to want. And when I do want to, I haven't the slightest clue how to proceed. I think to myself, if only I'd left a trail. You know, the way people make marks on trees to keep from getting lost in the forest? But somehow I never do. Or, by the time I think to do it, I've already lost the will to start [...]"

A 'literary' portrait does not have to be fictional. Consider for instance this passage in Sylvia Plath's semi-autobiographical novel *The bell jar* (1963). The narrator is describing her condition just before a visit to a doctor for assessment (122-3):

> I was still wearing Betsy's white blouse and dirndl skirt. They drooped a bit now, as I hadn't washed them in my three weeks at home. The sweaty cotton gave off a sour but friendly smell.
>
> I hadn't washed my hair for three weeks either.
>
> I hadn't slept for seven nights.
>
> My mother told me I must have slept, it was impossible not to sleep in all that time, but if I slept it was with my eyes wide open, for I had followed the green, luminous course of the second hand and the minute hand and the hour hand of the bedside clock through their circles and semi-circles, every night for seven nights, without missing a second, or a minute, or an hour.
>
> The reason I hadn't washed my clothes or my hair was because it seemed so silly.
>
> I saw the days of the year stretching ahead like a series of bright, white boxes, and separating one box from another was sleep, like a black shade. Only for me, the long perspective of shades that set off one box

> from the next had suddenly snapped up, and I could see day after day glaring ahead of me like a white, broad, infinitely desolate avenue.
>
> It seemed silly to wash one day when I would only have to wash again the next.
>
> It made me tired just to think of it.
>
> I wanted to do everything once and for all and be through with it.

This could be simply an exquisitely observed literary evocation of major depression; but it is simultaneously a personal record or something very close. Not only do we know a great deal about the details of Plath's life; we also have two extraordinary poetic witnesses to it. One is her own verse, particularly the mature work written between 1956 and her death by suicide in 1963; the other is the tribute and quasi-biography by her one-time husband, the late Ted Hughes (*The birthday letters*, 1998).[37] I am no fan of 'psychobiography', either of the recently or anciently dead; I am even less happy with the idea of using art as a 'clinical' record of an illness, or a mere map of an artist's psyche. I agree with Kay Jamison's judgement (1993: 258) that

> there must be a serious concern about any attempt to reduce what is beautiful and original to a clinical syndrome, genetic flaw, or predictable temperament. It is frightening, and ultimately terribly boring, to think of anyone—certainly not only writers, artists and musicians—in this limited way.

But without descending to demeaning and prurient exploitation, I think the work of gifted writers can capture the feel of major psychiatric illness much more compellingly than non-literary prose—as indeed Jamison does, since she uses poetic illustrations for precisely this purpose. Plath and Hughes show the reader something special about what the depths of depression and the peaks of mania are like. They give us the sufferer's self-portrait, and the outsider's depiction, by an equally gifted but not manic depressive poet who shared the most harrowing part of her life.

I hesitated at first about including this material; Hughes is just a few years dead, and there is something so raw about the *Letters* that it seems almost in bad taste to use them for an 'ulterior' purpose. Hughes himself had a strong distaste for the scholarly Plath-industry that grew up after her death, which I share in part (at least its voyeurism). I have tried to avoid this; I merely want to exemplify the particularities of a disease with the most potent expressions I know, ones that moved and harrowed me both with a sense of familiarity, and of frustration with my own lack of skill and imagination.

Throughout her poems and Hughes' the familiar themes of manic depression surface. When he first meets her she is manic, with the glow and charisma so often associated with 'good' (hypo)mania ('St Botolph's', *BL* 15):[38]

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[37] And now a long-term if often rather diffuse picture is available in Plath's journals (Kulkil 2000).

[38] All quotations from Hughes 1998, abbreviated *BL*, and Hughes 1981, abbreviated *SP*.

> Taller
> Than ever you were again [...]
> And the face–a tight ball of joy [...]
> And your eyes
> Squeezed in your face, a crush of diamonds,
> Incredibly bright, bright as a crush of tears
> That might have been tears of joy, a squeeze of joy.

But he also sees her as deeply wounded (‘Your Paris’ *BL*, 37):

> What walked beside me was flayed,
> One walking wound that the air
> Coming against kept in a fever, wincing
> To agonies.

This echoes Plath’s own self-perception (‘Street song’, *SP*, 35-6):

> By a mad miracle I go intact
> Among the common rout
> Thronging sidewalk, street,
>
> And bickering shops;
> Nobody blinks a lid, gapes
> Or cries that this raw flesh
> Reeks of the butcher’s cleaver [...]

She hides her real self, as so many of us do, trying to seem ‘normal’ (‘Street song’, *SP*):

> To ward off, at all cost, suspicions
> Roused by thorned hands, feet, head,
> And that great wound
> Squandering red from the flayed side.

But she was not always successful in concealment, at least in her own vision of herself in a poem written three years later (1959: ‘The ravaged face’, *SP*, 115):

> Outlandish as a circus, the ravaged face
> Parades the marketplace, lurid and stricken
> By some unutterable chagrin,
> Maudlin from leaky eye to swollen nose,
> Two pinlegs stagger underneath the mass.
> Grievously purpled, mouth skewered on a groan,
> Past keeping to the house, past all discretion–
> Myself, myself!–obscene, lugubrious.

This is the raging, wounded, crucified ‘hot’ side of depression; the other side is cold, bleak,

attenuated, as in ‘Frog autumn’ (1958: *SP*, 99):

> Summer grows old, cold-blooded mother.
> The insects are scant, skinny.
> [...]
> The sun brightens tardily
> Among the pithless reeds. Flies fail us.
> The fen sickens.
> [...] Our folk thin
> Lamentably.

But glorious as some of her manias are, they are not all brilliant and seductive; they too have a dark side. Their relationship is constantly battered by seemingly unaccountable outbursts of rage and noncommunication (Hughes ‘The rabbit catcher’ *BL* 145)

> What had I done? I had
> Somehow misunderstood. Inaccessible
> In your dybbuk fury, babies
> Hurled into the car, you drove [...]
>
> Your Germanic scowl, edged like a helmet,
> Would not translate itself. I sat baffled.
> I was a fly outside on the window-pane
> Of my own domestic drama.

Her terrifying engagement with sleep forms another strand (‘Dream Life’, *BL* 141):

> As if you descended in each night’s sleep
> Into your father’s grave
> You seemed afraid to look, or to remember next morning
> What you had seen. When you did remember
> Your dreams were of a sea clogged with corpses,
> Death-camp atrocities, mass amputations.

When, that is, she was lucky enough to sleep at all; here she portrays her own grim wakefulness (‘Zoo Keeper’s wife, *SP* 145):

> I can stay awake all night, if need be—
> Cold as an eel, without eyelids.
> [...]
> Should I stir, I think this pink and purple plastic
> Guts bag would clack like a child’s rattle,
> Old grievances jostling each other, so many loose teeth.

By 1962, the year before her suicide (and who in such a state would not welcome death?), there are what we can see by hindsight as prefigurations (‘The birthday present’, *SP*, 206ff):

I do not want much of a present, anyway, this year.
After all I am alive only by accident [...]

Only let down the veil, the veil, the veil.
If it were death

I would admire the deep gravity of it, its timeless eyes [...]

There would be a nobility then, there would be a birthday.
And the knife not carve, but enter

Pure and clean as the cry of a baby,
And the universe slide from my side.

On 5 February 1963, six days before her death, she wrote what can now be seen as a decision made into a poem, with the calm of the committed suicide (‘Edge’, *SP* 272):

The woman is perfected.
Her dead

Body wears the smile of accomplishment,
The illusion of a Greek necessity

Flows in the scrolls of her toga.
Her bare

Feet seem to be saying:
We have come so far, it is over.

After too long a turbulence, the cool perfection of death. Unnumbered others of us have experienced, at least in prospect, something like this near-classical augury of release; probably a quarter have gone through to resolution. Few if any have captured the whole experience, including the moments before the end, in language so evocative as Plath and Hughes, though Hughes realised the inevitable conclusion only in retrospect (‘The 59th Bear’ *BL*, 94):

I had not understood
How the death hurtling to and fro
Inside your head, had to alight somewhere
[...].

Reflections on signs of depression

Together with the disorderly story in chapter 1, these observations, from the 14th century to the present, should help give some life and human richness to the somewhat arid terminology of psychiatric discourse. Gail Godwin’s description of the change in Walter’s voice is particularly

acute. I have noticed in myself and others that depressive states are often accompanied by a loss of laryngeal muscle tone, which results in a flat and unresonant voice quality, very different from the speakers's usual voice. Volume levels are lower, and normal pitch-movement may be lost or greatly reduced. The general effect is a kind of feeble monotone, very like a Parkinson's patient. This may be (and often is) accompanied by a more general motor retardation or a postural collapse: movements may be slow and clumsy, or in extreme cases (as in Plath's description) movement itself becomes nearly impossible, and the patient loses even the desire to keep minimally clean. This is typical of severe depression; it shows also in Walter's feeling of being 'trapped' behind his curtain: he simply hasn't the energy to try to find his way out, and can only wait passively for it to lift. Note also the kinds of thoughts these characters show, not dissimilar to some of mine in chapter 1, but more clearly focussed. Nothing is worth doing, anything that eventually gets done is of poor quality. Walter and Ruth judge his sermons from completely different points of view, and Walter feels 'fraudulent'; at least his judgements are off centre compared to those of the non-depressed people who surround him, and all his thoughts are unshiftably and even assertively negative.

Up until the point I wrote this I had noticed such signs in myself and to some extent in others; but what I had never seen was the actual birth and flowering of a major depressive episode right in front of me, in my own house, with all its physical accompaniments. In 2007 I saw this for the first time, and felt able to describe the situation from the outside: what does one see as a depression descends on someone, what are the physical and mental symptoms and their linguistic correlates? My depressive friend K came over one day to show me something she had written; we had a few drinks, and were sitting together, both in quite 'normal' or neutral moods, at opposite ends of the couch in my sitting room (the couch is a little under six feet long), and I was reading what she had brought and we were discussing it, but not looking at each other, since I was looking down at the paper. Then she suddenly went silent, which is odd for her, and I turned and looked at her. She was another person. Her eyes, which are usually quite sparkly, had gone what I could best describe as opaque and she was weeping slightly, silently; her posture, which is usually straight (she's a tallish, angular, rather fit-looking girl) had collapsed in on itself, and she looked as if she had no muscle tone at all. Her face, which is usually very mobile, was like a Parkinsonian mask. I asked her (inanely) if she was OK and she said No. I had known for a couple of years that she is depressed and on meds, but I had never seen her in anything but good moods. I then asked her if I should leave her alone (which would have been my preference) but she said No.

Then she remarked that all the colours in the room had gone dim. It was like the verse of Thomas Nashe quoted in chapter 1: brightness literally fell from the air for her. I have experienced this hundreds of times when crashing. But I have only felt it in me; I had never *seen* what it looks like in another person at the critical moment. It is really rather terrifying. I am so used to managing states like this from the inside that I had never thought very deeply about what they look like, and had never had to engage with anybody in quite this condition. So I asked her if she wanted me just to keep her company and be silent, or if she wanted to talk. It was the latter, and we talked rather sporadically with long pauses for hours. I felt like a first-year psych student who

hadn't read the textbook yet, so I just followed my intuitions. It was harrowing—she is very bright and articulate and insightful, and a sharp observer of internal states, and I kept feeling that everything she said was a description of me at my worst. So I used that as a kind of peg to hang discourse on, and we shared awfulnesses, which seemed to make her feel a bit better. She kept apologising for being foolish and embarrassing me, and I kept telling her she didn't have to, that I knew perfectly well what it was all about, and so on. Then I asked her if she wanted to try going to sleep; the couch is long enough and I could just throw a duvet over her and let her sleep it off if she could. But she didn't want to. Then after some hours she suddenly said 'the colours are coming back', so I heaved a large sigh to myself, and just waited. And within about half an hour the worst had passed, and she was OK but a little shaky and muted.

I asked her during the long talk if collapses like this happened frequently; she said she thought maybe the meds were beginning to fail, as it was happening a little more often, though it had periodically during the 5 years she had been on the current drug. Nothing unusual about that, one often has breakthroughs during treatment with a drug that is actually working. Then I asked her if it ever happened in public before, and she said yes, even at parties. I asked her what she did in such cases and she said she found a room to hide in and rolled up into a ball.

A few months later, after reading this description, K sent me an e-mail in which she said that she was surprised, she had thought the episode had lasted only a few minutes rather than hours. It made me reflect on what can happen to mind and time. In a major depressive episode your time sense may vanish, because all you are conscious of is misery, and that is timeless. There is no flow, just stasis. I have often had the feeling in bad episodes that I was not in the world any more, rather in a kind of timeless, featureless hell, where notions like the flow of time were irrelevant or not even conceivable. Endless and therefore without temporal extension, if that does not sound too paradoxical.

The terms 'sign' and 'symptom' are usually distinguished in medical discourse: a sign is what the physician sees, a symptom is what the patient experiences. Since at this point we are looking at depression from the outside, as observers, we can think in terms of signs, the outward manifestations of what is going on inside (whether the sufferer is even aware of it, which is not always the case). Perhaps the most extreme example of the sign/symptom dichotomy is the type of depressive known as a 'somatiser' (literally somebody who 'embodies' his symptoms so that they appear to be purely physical: see López-Ibor 1991). Such patients may respond with indignation to the idea that they are depressed, as people so often do at the slightest hint of anything 'mental' (or worse, 'merely mental') being wrong with them.[39] Very often patients who

[39] The stigma attached to the 'psychosomatic' is a relic both of the Christian tradition making *Accidia* a sin, and Freudian and post-Freudian notions of 'hysteria' and 'neurosis'. People would rather have what they think of as 'real' illnesses, since according to the folk consensus bodily decrepitude is somehow more respectable than mental. Many people seem impervious to any explanation or demonstration that a 'mental' problem can produce perfectly ordinary physical disease, for example through the mediation of bodily systems that react to stress. There are also cultural determinants; depressives appear to somatise more often in some cultures than in others, and somatisation may even be the primary presentation. See Wolpert 1999: chapter 4.

later turn out to be depressed may present with such apparent irrelevancies as gastrointestinal symptoms or physical pains that appear to have no discoverable organic source, like headaches, muscular pain, backache. If depression is eventually diagnosed (not everybody who suffers from vague and untraceable pains of course is depressed), this looks rather like a special case of 'referred pain': that is, the brain problem is referred to somewhere else, via a complex system of messengers and channels.

Since depression is, as we will see, a disease of a system or set of systems tightly connected to each other and the whole body, many of its presentations (as in somatisations) will be visibly physical. Posture may be affected: there is a highly characteristic 'depressive droop'. Motor retardation will often be accompanied by loss of muscle tone, with slack shoulders, as if the effort of keeping them level is too much, and a characteristic facial expression. The corners of the mouth turn down, the facial musculature sags, as if gravity is forcing the entire face downwards. I experience this myself at the beginning of a severe depressive episode; my face feels slack and immobile, a mask incapable of expression.[40] I even look different in the mirror when I shave in the morning (if I bother to). This is often accompanied by pallor. Experienced doctors are aware of this expression, and can spot it immediately—as can other depressives. In the irritable phases of depressive episodes there is often a characteristic 'puritanical, disapproving' tightening of the lips as a primary response to being addressed on any topic. Obsessive rubbing of the face, especially the forehead and eyes, is common, particularly when the patient is seated.

In chapter 1 I might have given the impression that depressive episodes are 'all down', and (hypo)manic ones 'all up'; the discussion of mixed states above should disabuse the reader of that simple view. In fact depressive illness can be extraordinarily paradoxical in its mixture of presentations. Often a depression will present with irritability and bad temper and momentary (or even extended) explosiveness as primary signs. A person mired in an almost catatonic depression may respond with rage to the slightest annoyances, like the telephone ringing, some minor disarrangement of household routine, having to wait in a queue. The difference between this irritability accompanying depression and that of mania or hypomania is that it is usually transient (though at times, without transition to a manic or hypomanic state, the irritability and anger can last for a day or more), and the depression proper quickly returns.

The intricacies and possible interactions with 'base-line' temperament are horrendously complex, and have led to new kinds of classifications. Aside from the mixed bipolar states discussed earlier, some clinicians identify 'depressive mania' (dysphoric mood with rushing speech and increased activity), 'agitated depression' (low mood, pressured speech, increased activity), and 'depression with flight of ideas'(low mood, speeded-up thought, decreased activity).These could all probably come under the heading of mixed states. There are also

[40] On reflection there is something very Parkinsonian about depressive immobility; even facial expressions resemble the classical Parkinson's 'mask'—the slightly downturned mouth, the near-total lack of expression except for a rather blank stare, the immense difficulty of producing any expression at all. It may not be a coincidence that the same neurotransmitter whose lack produces Parkinsonism (dopamine) is also dysregulated in certain depressions, or that some antiparkinsonian drugs may have mania as a side-effect.

classifications based on the interaction of temperament (assumed to be a stable ‘trait’ rather than a changeable ‘state’) and mood disorder (Carver 1997):

1. Depressive Mania: Depressive temperament + mania
2. Dysphoric Mania: Irritable temperament + mania
3. Depressive Mixed State: Hyperthymic temperament + depression
4. Labile Mixed State: Cyclothymic temperament + depression.

The title of this chapter was not chosen lightly. Depressive disorder, unipolar, bipolar, mixed, has many faces, probably more than we can recognize yet, and some of them have not been seen clearly enough for us to draw them accurately. But we know enough to sketch the depressive universe, and fill in reasonable pictures of some of its inhabitants. Recognition or diagnosis of depression however, as of any other disease, is only the beginning; once you know what you have (more or less) the question is what to do about it. And here we open a Pandora’s Box, a can of many-splendoured worms, whatever mixture of grisly metaphor you like. Much of the rest of this book will be devoted to the experiential, theoretical, scientific, therapeutic and philosophical issues that arise from decisions about what sort of action ought to follow a diagnosis, and what in fact is being diagnosed. I have said nothing so far about causality or mechanism, treatment or about the disordered system itself. These issues will emerge in the following chapters.

This will require a number of what may seem to be diversions, into neuroanatomy and brain chemistry, the endocrine and immune systems, evolution and genetics, the philosophy of science and the philosophy of mind. But it is impossible to go any further in an intelligent way without getting into this morass. Medicine is (or ought to be) based on science, and without some basic neuroscience we will have no context for observation or explanation; and without some philosophy we will fail to understand the implications of what the neuroscience tells us.

Philosophical epilogue: the perils of precision

> I’ve specialised in the treatment of schizophrenia for twenty years, and I still don’t know what it is.
>
> —Cape Town psychiatrist

The naming of things

This topic may seem somewhat off my main track, but it is central to major issues in diagnosis and therapy. The discussion is at first sight more about the philosophy of science than the diagnosis and description of depression, but this is only apparent. In any case the issues have already been raised implicitly, and I add some further discussion here for those interested in a more explicit treatment. Besides, these topics obsess me, and I am not one to forego the pleasure of indulging my obsessions.

As I suggested earlier in discussing the *DSM*, there is a kind of magic in names. The

'proper' names of things are so important that in some religious traditions there is a magical significance in the name(s) of the deity; in orthodox Judaism the name of God cannot be uttered in its proper form outside of ritual contexts, but must be given in paraphrase or substitution, often with the word 'name' added to it to show that it is a magical token by virtue of its naming. The commonest form of the name of God in secular mention rather than ritual use of a Jewish prayer is *Ado-shem*, literally 'Lord-name'(*-shem* is a form of the root *shm* 'call, name'). God is often in fact referred to simply as *Ha-shem* 'the name'. There is a general assumption that names either have or grant a special kind of reality: if you know something's 'true' name you have power over it. And contrariwise, having a name for something often carries with it the conviction that the name must refer to something real—otherwise it wouldn't *have* a name.[41]

This onomastic mysticism is not merely the province of the primitive, half-educated or naive; something similar underlies much scientific classification. Since ancient times there have been two contrary views of what human classifications (of natural objects, diseases, etc.) represent. One is called 'nominalist': our classifications are simply naming-systems that reflect our current needs, and do not necessarily correspond (at least in detail) to anything 'out there' in the real world. More technically, they are not isomorphic to the reality they purport to model. The contrary view, reflected most extremely in name magic, is 'realist' or 'essentialist'. Its dominant form is the Platonic (and later Aristotelian) view that classificatory categories refer to 'real essences': the world is organised into discrete categories, and the scientist's task, invoking Plato's famous metaphor, is to 'carve nature at its joints'. The 'joints' are assumed to be real things in nature, and our job is to find them.

The joints separate 'natural kinds'. Each one occupies a unique pigeonhole, with no crossing of borders, no overlaps. If X and Y are natural kinds, then a given object must be either an X or a Y: there is no in-between or fuzzy choice, there are no clines in nature (Aristotle's 'principle of the excluded middle'). This view invokes two categories of being, form and matter. Form defines the 'essence' of a category; any individual example is a (more or less imperfect) manifestation in matter of that ideal form. An individual, besides being assigned to a natural kind on the basis of its underlying essence, may also have 'accidental' or non-defining properties. So for instance if the essence of Man is rationality, this is a real formal 'property', and 'the rational animal' is a'real definition'. But in addition to real properties there are also 'accidents'. Man may also be defined as 'the featherless biped', but this is merely a 'nominal definition' (the sets of rational animals and featherless bipeds happen, contingently, to intersect). To clarify the 'essence' vs. 'accident' distinction, a one-legged man is still a man, and a kangaroo or a plucked chicken is not.

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[41] In the early 1990s, a 'Witchcraft Conference' was held in South Africa's Northern Province, one of the poorest and most rural. There had been an outbreak of 'witchcraft-related' murders, including the burning alive of suspected witches. The courts trying these cases were western courts, and actions that took place in traditional tribal societies were being heard before magistrates working under Roman-Dutch law. One of the judges, when challenged on the matter of the existence of witches, remarked that they occurred in Shakespeare's *Macbeth*; this meant that there must have been witches in Elizabethan England, so why not in 20th -century South Africa?

But what if nature is really more like a dish of rice pudding? Can it then have proper joints? This is parallel to a problem that has been exercising evolutionary biologists recently: the validity of the concept 'species', once thought to be the indispensable classificatory foundation of biology. Are species really 'individuals', or are they merely the accidental by-products of sexual reproduction? There are certainly organisms to which the concept does not really seem to apply: there are no 'species' of bacteria in the sense that there are species of birds or mammals.[42]

Perhaps the most famous attack on Aristotelian essentialism is by the 17th-century English philosopher John Locke (*Essay on human understanding*, 1690, III.vi). Locke denies that categories are sharp-edged, and sees the world as a continuum rather than a set of discrete essences:

> There are some brutes, that seem to have as much Knowledge and Reason, as some that are called Men [...] and so on till we come to the lowest and the most inorganical parts of Matter, we shall find everywhere, that the several Species are linked together, and differ but in almost insensible degrees.

Under this interpretation, classificatory decisions are ultimately just that: arbitrary or conventional stipulations about where to draw lines, not 'recognition' of real essences. Definitions therefore are always nominal. In the words of the philosopher Michael Ruse, we define things 'by their agreement, or disagreement, with the complex idea' that a given technical term stands for. He characterises the difference between the Aristotelian and Lockean approaches as 'the objective approach, versus the subjective [...] The approach which *finds* natural kinds, and the approach which *makes* them'(1993: 101).

This is not just a pedantic excursion; the problem of essentialism lies at the heart of psychiatric diagnosis. It should be clear by now that the *DSM* criteria are essentialist, as opposed to the more ambiguous and subtle categories discussed under the heading of mixed states and those listed at the end of the previous section. To put it another way, the *DSM* is category-driven, while other taxonomies may be theory- or observation-driven. This leads to a paradox: the *DSM* classification, intended as a clinical guide with the aim of producing uniformity of diagnosis, is actually more valuable as a research instrument than for its original purpose.[43] That is, if you are running a clinical trial of a drug for Bipolar II disorder, it is vital that all the subjects be 'genuine' Bipolar IIs, according to some prespecified criteria that investigators and readers of the final report will agree on and take to be significant. And the easiest and most convincing way to achieve this is an essentialist take on psychiatric disorders, so that 'atypical' subjects can be

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[42] For the argument that 'species' is not a fully respectable concept, see Smith & Szathmáry 1995: chapter 9. The inapplicability of the species concept to bacteria is discussed in Smith & Smith 1999.

[43] This is a fairly general problem in medical practice. One neurologist, in a discussion of 'academic' vs. 'clinical' medicine, told me that he has great difficulty in applying the results of clinical trials and classificatory schemes in his clinical work, because patients refuse to be statistical, but tend to be idiosyncratic. For him, statistical generalisations (recall that the *S* in *DSM* stands for 'statistical') tend at best to be heuristics: clinical diagnosis is probably as much 'art' as 'science'.

excluded, producing clean and reliable statistics.

Of course the problem that this approach runs into, both in clinical practice and research, is the extreme complexity and variability of the human psyche. Clinical presentations may be as unique and variable as individual patients, and atypicality may be more typical than typicality —not compatible with hardline essentialism. This is particularly apparent in the emphasis on showing a particular number of signs out of a given cluster, and the time these symptoms have to last. Unfortunately, this can lead quite easily to *reductio ad absurdum*. For instance a Major Depressive Episode is supposed to last for two weeks; but there are episodes (I've had a good many) that meet all or most of the symptomatic criteria, but are much shorter. Am I to be diagnosed as say '*n* days short of Major Depression'? These problems are eventually picked up under rather poorly conceived and evasive headings like 'Not Otherwise Specified', or with special labels lower on the diagnostic hierarchy. But this may misconceive the nature of psychiatric illness. Given personal variability and people's unique and contingent life-stories, it may not be possible to use these criteria as anything more than rough indicators, rather than as 'real categories' in the world that can be given 'accurate' numerical values in a coding system (which automatically makes them 'real' in the name-magic sense). Sensitive and experienced clinicians (and researchers) are of course aware of these problems, and can circumvent them; but the classical 'memorise and regurgitate' mode of much medical teaching, and the diagnostic convenience of these essentialist pigeonholes, tend to elevate them to a greater importance than they really ought to have, and may lead less experienced clinicians to miss patients in need of help.[44]

Disease, illness, disorder

The essentialist problem recurs at the most basic level of all: the decision as to whether a condition seen by a doctor is a treatable 'disease'. The tradition begun in the late 19th century by Emil Kraepelin, and continuing through the latest revision of the *DSM*, is 'universe-defining'; its concern is the classification of mental disorders (technically the production of a 'nosology'), and their grouping into coherent subclasses that make some sense of the protean conceptual wilderness of human behaviour. A look at the conditions included in successive editions of the *DSM* is instructive: certain 'mental disorders' in early editions are no longer part of this universe (e.g. homosexuality); and new ones have been added (e.g. Post-Traumatic Stress Disorder). Some of these decisions represent genuine accruals of new knowledge, and recognition of specific syndromes with repeating symptomatic profiles; others are not so much medical decisions proper, but reassessments based on social and ideological change. The identification of PTSD is an example of the first, the exclusion of homosexuality of the second. This is problematic for an essentialist universe: essences keep accruing and getting lost.

The apparent taxonomic luxuriance of the 'classifiers' led in the 1960s to a backlash, as

[44] For a useful discussion of these issues see McHugh & Slavney 1998: chapter 3.

radical as its target. The American psychiatrist Karl Menninger went so far as to claim, in a highly influential book (1963, quoted in Barondes1999: 36), that

> Perhaps there is only one class of mental illness—namely mental illness. We propose that all the names so solemnly applied to various classical forms and stages and aspects of mental illness in various individuals be discarded.

The consequences of this programme, if they had really been carried through and become the basis of psychiatric treatment, would have been deadly. There was an immense amount of detailed, intelligent observation and classificatory work done by 19th-century psychiatrists and neurologists, Kraepelin and his school, Freud, and others. In the light of this heritage, Menninger's judgement is conceptually equivalent to saying that 'perhaps there is only one kind of stomach disease—namely stomach disease'. In that case cancer of the stomach and ulcers are just 'stomach disease', and can be treated as a single entity. I am sure that a physician of Menninger's class would not have thought this way about 'physical' illness; the fact that he could treat mental disorders in this kind of philosophically high-handed fashion suggests that he himself suffered from a fairly serious case of dualism (see the following chapter for a definition and discussion).

The anti-classification movement of the 60s culminated in the bizarre 'anti-psychiatric psychiatry', one might call it, of Thomas Szasz. In a number of unfortunately rather influential works, Szasz carried the idea of there being only *one* kind of mental illness to its obvious conclusion: there's none at all. As he wrote (1961, quoted Barondes 1999: 37):

> It is customary to define psychiatry as a medical specialty concerned with study, diagnosis, and treatment of mental illnesses. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social and ethical problems in living.

This is not the whole of Szasz's position; he saw psychiatry with its stress on 'illness' and 'disease' as essentially a form of social control or oppression. This ideology is still unfortunately prevalent among some people today, and was bolstered by the Orwellian use of psychiatric facilities by the former Soviet Union. If there, why not here? But one could still, as with Menninger, see a danger: if conditions like the ones described in this book are merely 'personal, social and ethical problems in living', then the same description could be applied to sexually transmitted diseases or tuberculosis. There is a profound confusion here between certain accompanying and/or precipitating factors and a collection of symptoms, the 'condition itself'. I would not deny the possibility—in any country—of psychiatry being used as form of 'mind-control', for enforcing social norms. But this is not grounds for a blanket condemnation of the discipline, or an excuse, sanctifiable by Szasz's apparent humanitarianism, moral goodness, and/or political correctness, for incoherent and unscientific reasoning. His central claims—which like Menninger's, solve the terminological and conceptual problems by making the issue

vanish—would nowadays (I hope) not be taken seriously by any conscientious psychiatrist.

But even within the responsible psychiatric community there is still some odd, and I think ultimately vexatious, terminological debate, particularly on the question of whether a given syndrome does or does not represent a 'disease'. Some psychiatrists make a fairly sharp distinction between 'disease' and 'disorder', and reserve the former term only for those conditions meeting particular criteria. For example, in the very widely accepted model exemplified by McHugh & Slavney (1998: chapter 4), something can be called a 'disease' proper only (a) if it is characterised by a 'syndrome', i.e. a cluster of specific symptoms that frequently co-occur; (b) if there is an identifiable neuropathology associated with it; and (c) if there is a known cause. In this framework a 'toxic psychosis' caused by alcohol abuse, with visible brain-damage, would be a 'disease', but the same syndrome in schizophrenia would not be. This is just playing with words—especially as many mood disorders associated with visible brain damage respond to the same kinds of drugs as those that have no such correlates.[45] I resort once more to my favourite rhetorical device, the *reductio ad absurdum*: if the argument is taken to its conclusion perhaps the majority of cancers would fail criterion (c), and would no longer be proper 'diseases'. Perhaps 'cell-replication disorders'? This debate is sterile, as debates about word-meaning almost invariably are. Words become more important as substantive issues become more tenuous. So I allow myself, throughout the book, to use the terms 'disease', 'illness', 'sickness' and 'disorder' more or less as synonyms. [46]

[45] For example, patients with frontal lobe damage often show typical depressive symptoms, such as low mood, lack of drive and inability to complete planned actions. These symptoms can often be alleviated by drugs that activate the neurotransmitter dopamine, which is one of those involved in depression (see chapters 3-4). This would suggest at least a strong kinship between some syndromes resulting from mechanical damage and others where no 'physical' cause (in the sense of one that can be imaged) is apparent. For details see Gualtieri 1995. We will also see in chapter 4 that the right kind of neuropathology does occur in depression anyhow, even though it is not correct to separate the 'mental' or 'behavioural' from the 'physical'.

[46] The issue of what a 'disease' is comes up as well in the context of the 'Darwinian medicine' movement, where symptoms or syndromes that can be shown to have evolutionary origins and perhaps some Darwinian advantage are removed from the category 'disease' in the strict sense. For a survey see Nesse & Williams1995: chapter 14.