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1

Depression is a Thing

"People who don't have depression have a lot of difficulty understanding it, but people who have it are also often befuddled by it."

– Chimamanda Ngozi Adichie[1]

Imagine a young woman in Philadelphia, a foreign student attending college and far from home for the first time. She is in a phase of sadness, close to despair. She feels isolated, but rebuffs people who invite her to social events. She lacks motivation, letting her room get messier by the day. Is this a case of clinical depression?

Imagine further that the student herself says no, rejects the label of depression when it is suggested by her aunt, a Nigerian doctor who is also a recent immigrant to the United States. She tells her aunt to stop using this American way of naming her distress. She does not have an illness at all, she says. Ifemelu, the main character in Chimamanda Ngozi Adichie's novel *Americanah*, believes she is having a normal reaction to her situation. She is poor, her undocumented status has made it hard to find a job, and she is far from loved ones. Who wouldn't have sadness, maybe some lethargy and social withdrawal? Uju, her aunt, believes she has a *real disease*, though one not talked about much in Nigeria. Americans, Ifemelu responds, have a disease for everything. Ifemelu's "symptoms" melt away without much comment once she finds a good job and makes friends.[2]

1

Depression is a Thing
抑郁症

"People who don't have depression have a lot of difficulty understanding it, but people who have it are also often befuddled by it."

"没有抑郁症的人很难理解　　但是
有这种病的人也常常对此感到困惑。"

- 奇玛曼达　恩戈齐-阿迪切

Imagine a young woman in Philadelphia, a foreign student attending college and far from home for the first time. She is in a phase of sadness, close to despair. She feels isolated, but rebuffs people who invite her to

想象一下 年青人 女性 在费城、 外国 学生 出席
学院 远离家乡 这是第一次。她正处于悲伤阶段、
关闭 到绝望。 她感到孤立无援、 却拒人于千里之外 邀请她
社会活动。 她缺乏动力、 让 她的房间 越来越乱
天。这是临床 抑郁症?

this American way of naming her distress. She does not have an illness at all, she says. Nemieli, the main character in Chimamanda Ngozi Adichie's

想象一下 进一步 that 学生 她自己 说不，拒绝接受
洼地 当建议 她的姨妈是尼日利亚人 医生
最近 移民 to 美国 国家。她告诉姑姑 to 停用
这个美国人 命名方式 她的痛苦。她没有疾病
她说。主角伊费内卢 在奇玛曼达 恩戈齐-阿迪切的
新奇 Amencanab、 相信 她过得很正常 反响 对她的处境
ation。 她很穷、 她的无证 地位使 很难 to 找到
工作，而她还远远没有 亲人。谁 不会 有悲伤，也许
有些倦怠 和社会退缩? 她的姑姑 Uju 认为她有一个真正的
疾病，尽管 一个在尼日利亚鲜有人问津的问题。 美国人 伊菲梅卢
回应、 什么病都有。 伊费内卢的"症状" 消融
不带 多说 一旦她找到一份好工作并交到朋友'。

The conflict between Ifemelu and Uju might seem to be a new one, peculiar to modern America's impulse to give medical names to life's problems. Yet the troubled distinction between depression and normal sadness runs through the history of the ailment. Can the border between the two be drawn sharply? Do they have the same sources, or distinctly different ones?

According to the World Health Organization, depression is now – newly – the single biggest contributor to the global health burden.[3] They estimate that there are more than 300 million people worldwide living with depression, with an 18 percent increase between 2005 and 2015. Between 2011 and 2014, about one in nine Americans said they took an antidepressant.[4] Many of them took drugs named "antidepressants" for other problems, such as insomnia and pain management, but the diagnosis of depression has swollen massively.

The meaning of the swelling is not obvious, though. Are more people getting depression? If so, what is causing this epidemic? Doctors, though, may simply be diagnosing depression more. If so, are they catching more of the cases that were always there, or changing the norms for diagnosis? Or is the rising currency of the label "depression" influencing how people interpret their mental distress, whether it is profound psychic pain, or moderate unhappiness? How much does the mere presence of antidepressants influence the rates of diagnosis? *Counting depression is a vexed project.*

The different explanations for rising rates of diagnosis all have smart advocates. Those who think we are having more depression point to alienating or distressing aspects of contemporary life, from wealth inequality and violence, to social isolation brought on by social media.[5] Whether the world is any more depressing or alienating than it was 75 to 125 years ago, when the diagnosis was less common, is not obvious, though. We had lower rates of depression diagnosis during the First and Second World Wars, Western imperialism, Jim Crow, and the Holocaust. Early twentieth-century sociology is rife with laments about the alienation of modern, urban societies. The era's philosophy gave us elaborate arguments that life was absurd and without ultimate purpose.

So perhaps we are not living through an epidemic of depression but of *calling things* depression. This view usually goes with criticism of the pharmaceutical industry – which certainly does have a financial

interest in a broad definition of the illness. As inviting as this argument is, though, consider that before the era of rising diagnosis rates, mental health advocates sought better detection of depression, an illness they thought was *under*-diagnosed, and a terrible and needless contributor to human misery.[6] From their point of view, we are only now finding all the depression they believed was there all along. They were urging more diagnosis before drug companies were making money on blockbuster antidepressants.

Put more systematically: whenever any illness is diagnosed more than before, there are three possibilities. The first is what epidemiologists call "*rising true prevalence*" – an actual increase in the number of sick people. The second is *better detection*. If, for example, you use hospital admissions to count the number of people with a sickness, you only count the people who come in to the hospital. You might get a better count if you go door to door in a community. Better detection can also come if doctors and the public grow more aware of the condition, so more patients come into treatment. But what if what you are counting is itself changing? This is the third explanation, *diagnostic drift*. A diagnosis may be naming distress that before would have been covered by a different illness label, or perhaps not be an illness at all. In debates about mental health, these possibilities are often treated as competitors but two of them, or even all three, could be working in tandem.

Knowing the prevalence of a disease is challenging when its definition is stable and has a clear sign, such as a blood test. With an illness like depression it is even harder. *Counting depressions is a vexed project*, partly because depression is hard to define.

Depression, in a clinical sense, is a diagnostic term. The prefix "dia" means apart and "gnosis" is knowledge. To diagnose means "to know apart," to distinguish from something else. Doing this for depression has not proven easy.

What Is Depression?

Many have a loose sense of what clinical depression is – an illness of unusually low mood. That simple definition hides a lot of complexity and change.

Let's look at Major Depressive Disorder (MDD) in the current

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Let's look at Major Depressive Disorder (MDD) in the current

Diagnostic and Statistical Manual of Mental Disorders (DSM-5). MDD is the central diagnosis for depressive illness in the current manual, though other illnesses include depressive symptoms. The DSM-5 will not be the last word on what depression is. If the past is any guide, the category of depression will continue to transform. Discontent with MDD has already emerged. Some clinicians and researchers think MDD embraces too many subtypes of depression.[7] According to one recent textbook, "no clinician or researcher believes that MDD is a single 'illness.'"[8] More precision might lead to better treatment plans. For now, though, we lack a widely-agreed upon subdivision.[9] DSM-5 calls for MDD if five of nine symptoms have been present for a two-week period. The nine 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. Change in sleep – sleeping too little or too much
5. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

One of either of the first two listed symptoms must be present, but none of the rest are required, as long as four others are present. The manual also says that the symptoms must cause significant distress or impairment, and must not be caused by substance abuse, or by another illness.

Time is key. Symptoms have to be lasting for a diagnosis. But the

time given is arbitrary. I am not saying that the authors of the manual erred when they set the duration. They had to pick something, or else people could get a diagnosis after being in a bad mood and losing appetite for a few hours because of something the President tweeted. (This happens to me sometimes.) The right length of time, though, cannot be settled scientifically. Future research may refine our knowledge of depression to a point where the amount of time could be settled objectively. I doubt it.

We also frequently ask if the symptoms seem justified by events. Although not a factor in current DSM diagnosis, in much of Western history many definitions of depressive illness have insisted that the distress must be out of proportion to the life situation.[10] As early as the time of Hippocrates in Greek antiquity, some said melancholia was present only if the symptoms were not normal reactions to life events. A few centuries later, the physician Aretaeus wrote of melancholic patients being "dull and stern, dejected or unreasonably torpid, *without any manifest cause*."[11] Freud's classic work on the subject started with the premise of the difference between normal grief and melancholia without cause. One psychiatrist wrote in 1976 that depression differs from normal sorrow if it "seems exaggerated in relation to the supposed precipitating event."[12] This *proportionality criterion* – the mood must be out of proportion to the life situation to be called sickness – has had a deep mark on Western concepts of depressive illness, and continues to influence debate, even though it is not now an official part of diagnosis. It also likely influences paths to treatment – people undergoing clearly stressful losses may be slower to conclude they have an illness and need medical attention than people having the same feelings in the absence of those events. Ifemelu reminded Uju that if she was sad, she had reason to be. Ifemelu did not add that such sadness might be depression if her life situation were sunnier. That would, though, seem to save the label from the charge of making every bad feeling an illness. The proportionality criterion often poses challenges in practice, though. The fifth edition of the DSM removed the "bereavement exclusion" from the diagnosis of major depression. In previous editions, the symptoms didn't count toward a diagnosis if they came during mourning. Some psychiatrists worried that this change to the manual took a normal, if painful, part of life and turned it into an illness.[13]

诊断 and 统计 手册 精神 失调症 (DSM-5) 。 MDD
是中央 诊断 用于抑郁 疾病 在 当前 手册
尽管 其他 疾病包括 抑郁 症状 ~he DS~-5 will
不是抑郁症的终结者 是。如果过去有任何指导意义的话，the
类别 抑郁症 将继续 to 转型。 不满 at with
MDD has 业已 出现了 Some 临床医生 and 研究人员 觉得
MDD 拥抱 亚型太多 抑郁症。 根据 到一个
最近 教科书 "没有临床医生 或研究员 相信 that MDD is a
单一的'疾病"" More 精确度 也许 促进 待遇 计划。
不过现在 我们缺乏一个广泛认同的 upon 分区"。 DSM-5
呼吁 MOD 如果九种症状中有五种 一直以来 礼品 为两个
周。该 九个症状 are:

MDD embraces too many subtypes of depression.' According to one

1.抑郁 几乎每天的大部分时间都心情不好。

2.明显减少 利益 或快乐 或几乎 所有，活动
几乎每天的大部分时间都在打领带。

3.不节食时体重明显减轻 或重量 增加或减少
或食欲增加 几乎每天

For upon subdivision." DSM-5

4. 睡眠改变--睡得太少或太多

5.思维放缓 和减少 物理 运动
(他人可以观察到，而不仅仅是主观感觉的烦躁不安或行动迟缓) 。

6.几乎每天都感到疲劳或体力不支。

7.几乎每天都有无用感，或过度或不适当的负罪感。

8. 思考或集中注意力的能力减弱，或者优柔寡断，几乎每天都是如此。

9. 经常性 感想 死亡、 '循环性 自杀式 构思 不带 a
自杀计划、自杀未遂或实施自杀的具体计划。

or increase in appetite nearly every day.

One 或 前两项 症状 must be 现在 but
只要有另外四个，其余的都不需要。 手册还指出，"sym t'"
~必须不是由物质引起的 必须 造成重大 痛苦 or
疾病。 滥用、 或由他人
Time 是关键。症状 h .....到 be lastmg 或诊断、 But the

6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
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time 考虑到 是任意的。 我不是说 that 作者 手册
错误 when they set the 会期 They had to pick 什么的 or
其他人 可以 确诊 后 作为 不爽 并失去
胃口 tor 数小时 因为 的东西 the 主席 鸣叫。
(我有时也会遇到这种情况。) 不过，正确的时间长度还无法用科学方法来确定。未来的研究可能会完善 我们的知识
在抑郁症的边缘，可以客观地确定时间的长短。 我对此表示怀疑。

rs because of something the President tweeted

We also 常 问是否 症状 seem 有理 通过活动。
虽然 not 系数 在当前 DSM 诊断、 许多 西方
历史 many 释义 of 抑郁 疾病 have 坚 that the
痛苦 must 不相称 生活状况"。 早在
time of 希波克拉底 希腊语 古代、 some said 忧郁症 was
礼品 only 如果症状 不正常 反应 生活事件。
几个 世纪 稍后、the 医生 阿雷塔斯 所写 of 沧凉
患者 作为 "无趣 和船尾、 颓废 或不合理 迂腐、 '没有
原因是什么？" 弗洛伊德的经典 work 在 议题 开始 with
the 处所 的 差异 之间 正常 悲痛 and 忧郁症
不带 原因 One 精神病学家 所写 in 1976 年 洼地 不同
从正常 悲伤 如果"似乎 夸张 关于 对假定的
沉淀 "！' This 比例 准则 - 心情 必须
out 比例 生活状况 被称为疾病--曾有过
deep mark 关于西方 概念 抑郁 疾病，并继续 to
有影响的人 辩论、 纵使 它现在不是诊断的正式组成部分。
它还可能影响 路径 治疗 - 人民 进行中的 显然
紧张 损失可能较慢得出结论 他们有病，需要
医疗 注意 than 人民 拥有 同感 在没有
of 那些 活动 伊菲梅卢 提醒 Uju that 如果她 是悲伤的、she had
理由 to 是。Ifemelu 没有补充说这种悲伤可能是抑郁
如果她的生活状况 更阳光。 That 会、 虽然、 seem to 保存
从 指控 制作 每种感觉 一种疾病。".....。pro-
比例 准则 时常 姿势 挑战 在实践中、 虽然。 The
第五版 的 DSNI 删除 the 丧亲 排除" from
诊断 主要 抑郁症。 在以前的 版本 症状
没有 计数 进行中 诊断 如果他们来了 期间 哀悼。 Some
精神病学家 担心 that 这一变化 到手册 took 正常、 if
痛苦、 生活的一部分，变成 变成一种疾病。

sickness – has had a deep mark on Western concepts of depressive illness, and continues to influence debate, even though it is not now an official part of diagnosis. It also likely influences paths to treatment – people undergoing clearly stressful losses may be slower to conclude they have an illness and need medical attention than people having the same feelings in the absence of those events. Ifemelu reminded Uju that if she was sad, she had reason to be. Ifemelu did not add that such sadness might be depression if her life situation were sunnier. That would, though, seem to save the label from the charge of making every bad feeling an illness. The proportionality criterion often poses challenges in practice, though. The fifth edition of the DSM removed the "bereavement exclusion" from the diagnosis of major depression. In previous editions, the symptoms didn't count toward a diagnosis if they came during mourning. Some psychiatrists worried that this change to the manual took a normal, if painful, part of life and turned it into an illness.[13]

Consider heartbreak. Say you were deeply in love with someone who dumped you. You might have five of the nine symptoms above. Both medical and lay opinion usually say that we should not medicate heartbreak. But what if the symptoms last a long time, or become especially severe? If the heartache lasts for years on end, is it then an illness? At what moment does it become so? What if the heartbroken person becomes suicidal? We then might want to intervene medically. But exactly how far short from suicidality is normal enough to be out of the range of medical attention?

The questions lack objective answers. Both the time and proportionality criteria shift with cultural norms, historical moments, and even from person to person.

What Makes Something an Illness, Anyway?

The tacit question in the conversations between Ifemelu and Uju is, what makes anything an illness? How do we decide?

One option, often favored by people who dislike psychiatry, or want to reject a "medical model" is to say a physical lesion must be present. This is appealing. We like to have something we can see. But this is not how most societies have decided on illness states through human history, and it's arbitrary. Many lesions now known for illnesses were once unknown – was Alzheimer's Disease not an illness before Alzheimer identified the brain pathology? If we someday do find a clearer biological measurement of depression, would depression magically transform into an illness then, after being not an illness now?

Another option is to use illness to refer to atypical states or conditions, but atypical states are not always bad. We would not want to say that someone with unusually high ethical standards has "Excessive Morality Syndrome." We might, though, if it was causing undue suffering. So perhaps we should add that the condition must cause pain or limitations in daily life. But this could include everything from being left-handed in a world built for right-handed people, or being gay in a society that persecutes gay people. Psychiatry tried labeling being gay as an illness, partly with the hope it would diminish the stigma. The results were terrible.[14]

Psychiatrist Nancy Andreasen has argued that no one has developed

"successful, logical, and non-tautological definitions of … disease, health, physical illness, or mental illness."[15] She's right.

Attempts to separate "real" from made-up illnesses open a bottomless pit of philosophical debate. Some conditions are easily agreed upon – cancer (an illness), and left-handedness (not an illness), for example. More ambiguous cases can be tough. With agreement, the suffering person gets "the sick role," with the associated exemptions (such as missing work) and obligations (such as trying to get better). Medical care is appropriate.[16] But the agreement is the outcome of a social process. Even when a known physical marker is present, a social process decides whether it is a sign of illness.

People sometimes try to change the social agreements by adding or subtracting illnesses. In an effort at subtraction, libertarian antipsychiatrist Thomas Szasz – a fan of the "physical lesion" yardstick – excluded all of mental illness, and sought to take psychiatry out of medicine. Given how much of human history, all over the world, has seen things like psychotic symptoms, or disabling distress, as signs of illness, Szasz had a lot of success. But just as Szasz was free to question the medical status of mental illness, others were free to re-assert it. They had even more success. A more complete success in subtracting an illness came when gay activists challenged the label of homosexuality as an illness. They were not, they said, suffering from their same-sex attraction. They may have been suffering from lack of social acceptance, but calling their sexuality "illness" was not helping. It did a lot of documented harm.

As for addition, new illness states are being named all the time. I'm surly when I first wake up in the morning. Not an illness, right? But if I want to say I have "Morning Surliness Syndrome (MSS)," I can, and if a lot of people start to agree, then its status as an illness will be a social fact. Others can object, by saying we didn't always have this newfangled MSS, or asking where is the physical lesion. Ifemelu might say, how American this is, to call something an illness because the culture values morning perkiness. What would matter is how many people I convince, especially if they include doctors and insurers. If a drug could make you more perky in the morning, my success is more likely. This sounds like a fanciful scenario. But it is close to what happened with Erectile Dysfunction.[17]

考虑 心碎 说你 were 在深处 恋爱 with 有人
抛弃 你。您可能 九个 症状 以上。
医学和非专业意见 通常说，我们应该 not 服药
心碎 但是 如果 症状 last 长 时间 or 变成
特别严重？如果心痛 可持续数年之久、 那么 an
疾病？什么时候 是否成为 所以呢？什么如果 凄恻
自杀？那么我们可以 想插手 医学上。
但究竟离自杀还有多远才算正常呢？ 足够 不在
医疗服务的范围？
这些问题缺乏客观答案。时间和比例
一致性标准 随着文化 标准、 历史 时刻 and (even
因人而异。

person becomes suicidal? We then might want to intervene medically.

But exactly 什么造就了什么 疾病到底是什么？

The 默认问题 对话中 之间 伊菲梅卢 and Uju is,
何以见得 疾病？我们如何决定？
不喜欢精神病学的人通常会选择一种方法、 或想
摒弃"医学模式" 就是说一个物理的 病变必须 出席。
这很吸引人。我们喜欢有一些 我们可以看到。但这并不是
大多数社会是如何决定 疾病状态 通过 人 his-
这是很武断的。 目前已知的许多病变 曾经
未知--在阿尔茨海默氏症确定大脑病理之前，阿尔茨海默氏症是不是一种疾病？
如果有一天我们真的找到了更清晰的 生物
在测量抑郁症的过程中，抑郁症会不会在现在不是疾病的情况下神奇地转变为疾病？
另一个 选择权 是用疾病来指非典型的 国家 或条件
际关系，但非典型状态 不 总是不好。 We 就会 not want to
说有人 与众不同的 道德高尚 标准 有"过度
道德 综合症"。 We 可能、 虽然、 如果它导致 过分 suf-
因此，也许我们应该补充一点，即病情必须导致疼痛或限制
日常生活。但这可能 包括 一切 from 作为
左撇子在为右撇子打造的世界里生活 人、 或作为 同性恋
社会 迫害同性恋者。 精神病学 尝试过贴标 作为 gay
将其视为一种疾病，部分原因是希望借此减少耻辱感。结果非常糟糕！
精神科医生 南希-安德 缓和 h 有道理 d th 在无人开发

unknown – was Alzheimer's Disease not an illness before Alzheimer identified the brain pathology? If we someday do find a clearer biological measurement of depression, would depression magically transform into an illness then, after being not an illness now?

Another option is to use illness to refer to atypical states or conditions, but atypical states are not always bad. We would not want to say that someone with unusually high ethical standards has "Excessive Morality Syndrome." We might, though, if it was causing undue suffering. So perhaps we should add that the condition must cause pain or limitations in daily life. But this could include everything from being left-handed in a world built for right-handed people, or being gay in a society that persecutes gay people. Psychiatry tried labeling being gay as an illness, partly with the hope it would diminish the stigma. The results were terrible.[14]

Psychiatrist Nancy Andreasen has argued that no one has developed

"成功、 顺理成章、and 非神论 释义 of ... 疾病、
健康、 物理 疾病、 或精神 "! ' 她是 对
"尝试 分开 "真实" from 虚构 疾病 open 底层
少坑哲学 辩论。 某些条件 容易达成一致 upon
癌症 (一种疾病）、and 左撇子 "(not 一种疾病）、例如
More 含糊不清 案件 can 要强硬。 With 协议、 the 忧患
人品 "gets "the sick 角色"。with the 联合的 豁免 (这种 as
失踪)工作） and 义务 (这种 尝试 以获得 更好）。e医疗
care 是合适的。 But the 协议 是 结果 社会
过程。即使存在已知的身体标记，也要由一个社会过程来决定它是否是疾病的征兆。

h. With agreement, the suffering

人 有时候 设法改变 社会协议 加入 or
减法 疾病。 为了 减法、 自由主义者 精神病 s
托马斯 萨兹--"物理"的拥趸 病变" 准绳 被排除在外
所有精神 疾病、 and 寻求 to take 精神病学 out 医学。
鉴于 多少 人类 历史 世界各地、 见过世面
神经病似的 症状 或禁用 苦恼、 作为疾病的征兆，Szasz
取得了很大成功。 但正如萨兹可以自由地质疑 医学
地位 精神 疾病、 其他人 可自由重新断言 他们他们 甚至
more 成功。 更多 完整 成功 在减去 病来
when 同性恋活动分子受到挑战的 同性恋标签 作为一种疾病。
They (were not, they 说、 忧患)from (他们的同性 吸引力。
They 可能是 忧患 from 不被社会接受、 但调用
他们的 性行为 "疾病" 也无济于事。 它做了很多记录
伤害。mental illness, and sought to take psychiatry out of medicine.

至于加法、 新疾病状态 正在 名为 一直都是。 I'm
当 我每天早上醒来的第一件事就是 Not 一种疾病，对不对?但如果我
want 说我有"早晨 气势 综合症 (MSS)"。 我可以，如果
很多人 启动 同意、 then 其地位 作为一种疾病将成为社会
事实其他 可以反对、 说我们没有 总是有这种新潮的
t\lSS、 or 要求 其中 是 物理 病变。 伊菲梅卢 也许 说，如何
美国 这就是，将某物称为 病因 文化 价值观
早上 活泼。 What 会有关系 是多少人 我说服了他
尤其是 如果他们包括 医生 and 保险公司 如果药物 可以 make
更多 活泼 在早上、 我的成功更在于 有可能。这 声音
如遐想)场景 a但它与 发生了 (with 勃起
功能障碍"。

They may have been suffering from lack of social acceptance, but calling their sexuality "illness" was not helping. It did a lot of documented harm.

As for addition, new illness states are being named all the time. I'm surly when I first wake up in the morning. Not an illness, right? But if I want to say I have "Morning Surliness Syndrome (MSS)," I can, and if a lot of people start to agree, then its status as an illness will be a social fact. Others can object, by saying we didn't always have this newfangled MSS, or asking where is the physical lesion. Ifemelu might say, how American this is, to call something an illness because the culture values morning perkiness. What would matter is how many people I convince, especially if they include doctors and insurers. If a drug could make you more perky in the morning, my success is more likely. This sounds like a fanciful scenario. But it is close to what happened with Erectile Dysfunction.[17]

If you think social agreement is a bad way to decide on what an illness is, you are free to propose objective criteria. But you will have to get everyone to agree to them. Best of luck!

Psychiatric diagnosis causes more division than those in most areas of medicine. Labels change their meaning, drop out of use entirely, are occasionally revived. The history of psychiatry is strewn with labels with no real clinical purpose, and others that were well-meaning, but failed, attempts to dispel stigma. It is child's play to show that a DSM diagnosis is a "social construction." You can teach a class of college freshmen how in under ten minutes. And, psychiatric diagnoses are always to some extent a reduction. Using them can hide context, complexity, and subjective experience. The potential for harm, especially stigma, is always present. These drawbacks are not unique to psychiatry, though. Any diagnosis in medicine can stigmatize, even if stigma is greater for some than others. And any diagnosis is reductive if it draws attention from the larger context. Saying someone has tuberculosis does not reveal the social roots of the medical problem, in poverty or occupation, for example.[18] It can also miss cultural context; tuberculosis has had changing meanings and associations.[19] As I write, we are vividly seeing the dreadful effects of COVID-19. The virus is exploiting existing social inequalities and inflaming existing stigmas. These social dimensions are not captured by diagnosis alone. They also do not make the illness less real.

Psychiatric diagnosis is fraught, but that does not make it useless. Diagnosis provides a pathway to practical things like treatment and insurance coverage, and can also be comforting.[20] A vague sense that something feels bad can be a burden. Naming the feeling as an illness helps people make sense of pain, and can be a first step toward seeing it as a solvable problem. People may feel less alone, to know that their distress is something others know and recognize.

Many people write critiques of the DSM. These critiques often – and I mean *really* often – call the book psychiatry's "bible." By calling it a sacred text, these critics show their irreverence. The analogy is bad, though. Few psychiatrists regard the *DSM* as sacred, and most recognize its weaknesses.[21] Psychiatrists know the *DSM* fails to capture all the nuances of mental illness.[22] Criticism of the *DSM* is necessary, but not all that contrarian. Perhaps instead of using a manual we

should let clinicians use their judgment, based on experience, to make individualized treatment plans. This is what many do anyway, whatever they write on the insurance submission. Much would be lost without some standard manual, though. Clinicians would find it hard to communicate about patients, and research comparing patients would be hard to design. Many patients are dependent on third-party payment, and insurers want a classification system.

Critics of psychiatric diagnosis point to discredited diagnoses to claim the whole enterprise is flawed. Homosexuality is one example, but there are lots of others. In the nineteenth century, a racist White doctor said that escaped slaves in the American south suffered from "drapetomania," an illness whose symptom was the desire to be free.[23] Hysteria was a diagnosis that stigmatized women and was used to control them. Psychiatric labels often do have political and cultural bias. But these examples do not show that psychiatric labels have no possible value. To say they do is as dogmatic and uncritical as saying that they have perfect validity.

So, What About Depression? Is It an Illness?

The word "depression" refers to a sickness, but also to a mood everyone experiences. The mood ordinarily passes, and is often driven away with simple changes like going for a run, cleaning up your room, or taking a shower. Even when it lasts longer, it may pass in time, and fade as life gets better. Ifemelu's mood changed as she got a job and made friends. This does not mean she never had a clinical depression, and the novel never says for sure either way. But people who have not had the illness often struggle to see that it cannot be easily shaken off, and may require medical treatment.

Deciding whether depression is an illness would be easier if it were a less amorphous category. The number of symptoms that have been called symptoms of depression is huge. I began keeping a list of every symptom I found, in any context past or present, to be a symptom of depression (see figure 1). I have grouped them into three domains: (1) affective/behavioral – having to do with mood and actions, (2) psychotic – having a break with reality, and (3) somatic, or physical. Almost all depression diagnoses include affective and somatic items. Psychotic symptoms

If 我们认为社会协议 是一个糟糕的决定方式 关于 病态
您可以自由提议 客观 标准。 但你必须
让每个人都同意。祝你好运！.

to decide or what an ill-
精神科 诊断导致更多 除以 那些 10 most 地区
医学。 标签会改变其意义、 完全停止使用、 are
偶尔也会死灰复燃。在精神病学的历史上，到处都是没有真正临床目的的标签，还
有一些是善意的标签、 but
失败的尝试 消除耻辱感。 它是孩子的 播放到 show that a DS.\
诊断是一种"社会建构"。 你可以在十分钟内教会一班大学新生。 而且，精神病诊
断 are
在某种程度上总是减少。 使用它们 可以隐藏上下文、 com-
plexity，主观 经验 The 潜在的 伤害、 尤其是
成见，始终存在。 这些 缺点 不是唯一的 对心理
不过，还是要试试。任何医学诊断 会使人蒙羞、 即使有污名 is
对某些人来说，这比对其他人来说更重要 是还原的 如果绘制
注意 from the 更大 背景 说 有人 has 肺痨
并没有揭示医学的社会根源 问题 贫困 or
职业 举例来说。它还可能错过文化 背景 肺痨
有变化 意义 和协会。 正如我所写的我们 viv-
闲看庭前花开花落 COVID-19 的影响。 The 病毒 正在利用
现有的社会不平等现象 和发炎 现有的污名。 这些 社会
未捕获尺寸 仅靠诊断。他们 也不使
疾病不那么真实。
try. 精神科 诊断 是充满危险的but that does not make 毫无用处。
诊断 提供 途径 到实际 事情 like 待遇 and
保险 覆盖面、 也能给人安慰"。 模糊不清 感觉到 that
什么 感觉不好会成为一种负担。 命名 感觉 作为一种疾病
~帮助人们理解疼痛，并可作为第一步 进行中 所见
这是一个可以解决的问题。人 可能会感到不那么孤独要知道 that 他们的
危难是什么 别人知道并认可。 context; tuberculosis
Many 人民 写批语 的 DSM. 这些 批评 时常 -
~我是说真的 经常--把这本书称为精神病学的 "圣经" 通过拨打
它是神圣的 这些 批评家 show 他们的不敬。 The 比喻 is
不过，这很糟糕很少有精神科医生 问候 the DSM 神圣 and most
认识到自己的弱点"。 精神科医生 知道 DSM 未能捕获
所有 细微差别 精神 病"。 批评 of the DSlvl 必须
是必要的，但并不完全是逆向的。 也许 而是 使用 说明书 we
the illness less real.

Psychiatric diagnosis is fraught, but that does not make it useless. Diagnosis provides a pathway to practical things like treatment and insurance coverage, and can also be comforting.[20] A vague sense that something feels bad can be a burden. Naming the feeling as an illness helps people make sense of pain, and can be a first step toward seeing it as a solvable problem. People may feel less alone, to know that their distress is something others know and recognize.

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DEPRESSION IS A THING
应 让临床医生 使用他们的判断力 根据 经验、 使
个性化 待遇 计划。这 无论如何，很多人都是这么做的
they 写道 在 保险 提交。 Much 就会 失之东隅，收之桑榆
some 标准 手册 虽然。 临床医生 就会 吃力 来
调配 关于 病人 land 研究 比较 患者 就会 be
hard 到设计。 Many 患者 取决于 关于第三方 付款、
和保险公司 要分类 系统
sor 评论家 of 精神科 诊断 点 to 名誉扫地 诊断 to
声称 the 全部 企业 是有缺陷的。 是一个 例如
but 那儿 还有很多。 在 第十九 世纪、 种族主义者色
医生 said that 逃脱 从站 在 美国 南 蒙受 from
"窗帘躁狂症" 一种疾病，其 病状 是希望 自由"。
癔症 是诊断 that 被污名化 妇女 并被用来连接
trol 他们 精神科 标签 时常 确实有政治 和文化 偏颇。
但这些 例子 并不表明精神病学 标签不可能
价值。对 说他们 教条 不闻不问 他说 they,
十全十美 有效性。
but there are lots of others. In the nineteenth century, a racist White doctor said that escaped slaves in the American south suffered from "drapetomania," an illness whose symptom was the desire to be free.[23]
那么 关于 抑郁症? Is 这是一种疾病吗?
The "抑郁"一词 指的是 to 一种疾病，也是一种心情，每个人
经验 The mood 平时 他们经常被赶走
简单 变化 如去 跑步、清洁 你的房间 或采取
淋浴。 Even when 更持久、 它可能会随着时间流逝，随着生命消逝
变得更好。 Ifernelu's mood 变了 因为她找到了工作，交到了朋友。
This does not mean 她从不 有临床 抑郁症、 和小说
从不 可以肯定地说 方式。但人们 未患病者
时常 奋斗 看到它不能 容易甩掉，可能需要
医疗。
决定 是否 洼地 是一种疾病，如果它是一种
不那么无定形 类别 The 编号 症状 被称为
症状 抑郁症 是巨大的。我开始记录每一种症状
我发现 在任何情况下 过去或现在、 to 表征 抑郁症
见图 1).我已将 them into 三 领域: (1) 情感/
行为学 - 拥有 与心情有关 和行动、 (2) 精神病 - 拥有
一阵 with 现实 and (3) 躯体、 or 身体 几乎 所有
诊断 包括 情感和躯体 项目精神病 症状

simple changes like going for a run, cleaning up your room, or taking a shower. Even when it lasts longer, it may pass in time, and fade as life gets better. Ifemelu's mood changed as she got a job and made friends. This does not mean she never had a clinical depression, and the novel never says for sure either way. But people who have not had the illness often struggle to see that it cannot be easily shaken off, and may require medical treatment.

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Affective/Behavioral

- Depressed mood
- Loss of interest in things
- Guilt
- Sadness
- "Excessive" sadness
- Expectation of bad things to happen
- Rumination
- Social withdrawal
- Feelings of worthlessness
- Suicidality
- Trouble concentrating
- Cognitive dysfunctions
- Indecisiveness
- Agitation
- Anhedonia (the inability to feel pleasure)
- Irritability
- Hopelessness
- Labile mood
- Tension/nervousness
- Frequent crying
- Agoraphobia
- Hypochondria
- Existential angst
- Low motivation
- Suppressed emotion
- Feeling of "emptiness"

Psychotic

- Delusions
- Extreme paranoia
- Imagined poverty
- Hallucinations

Somatic[a]

- Digestive problems, including flatulence, constipation, stomach pain
- Motor retardation
- Insomnia
- Reduced sex drive
- Decreased or increased appetite
- Literal downcast eyes
- Low energy
- Sensation of bodily heaviness
- Reduced or absent menstruation
- Tension, especially in head or neck
- "Pins and needles"
- Heart, chest pain
- Paleness
- Sweaty palms
- Labored breathing
- Dizziness
- Bitter taste in the mouth
- Tinnitus
- Experience of darkness or mist in front of the eyes
- Cold hands and feet
- Trouble swallowing

There are overlaps in this list. To make the list as comprehensive as possible, I deliberately included possible redundancies. Many of these symptoms are also features of other mental illnesses, or of illnesses that are not considered "mental." A similar list appears in Ryder et al. (2008); I drew on it while composing this one. See Andrew G. Ryder, Jian Yang, Xiongzhao Zhu, Shuqiaou Yao, Jinyao Yi, Steven J. Heine, and R. Michael Bagby, "The Cultural Shaping of Depression: Somatic Symptoms in China, Psychological Symptoms in North America?" *Journal of Abnormal Psychology* 117 (2008), 300–13.

[a] Some of these are "reverse somatic," meaning a symptom that is the opposite of the expected symptom. For example, if being unable to sleep is a somatic symptom, sleeping too much would be the reverse somatic symptom.

Figure 1 *A (futile) attempt at a comprehensive list of depression symptoms in all contexts, past and present, sorted into domains*

belong, in most twentieth-century psychiatry, to particular subtypes, though they were more dominant in descriptions of melancholia.

With all the variability shown in figure 1, are we really talking about the same illness in all times and places? And yet, there are human universals: of body (brains, hearts, hormones, genitals, for example) and experience (hunger, pleasure, intimacy, grief, awe, and so on). They vary in form by culture, but even with immense variation, translation across cultural frontiers can be possible.[24] Virtually all human societies have a concept of mental sickness, or madness.[25] Does that include depression? Depression seems to fail the "physical lesion" test. In the absence of the clear physical lesion, the possible universality of depression as an illness might seem to do the same work: if it is an illness everywhere and at all times, then it must really be an illness – and if not, it might seem to be less real. But before getting into the question of depression's universality in detail, a caution: this criterion is no more definitive than a physical lesion. If an illness exists only in particular places and times, we can only conclude exactly that. We cannot conclude it is a fake illness. Illnesses particular to cultures are as real as any other.

Do They Have Depression Everywhere?

If the debate between Ifemelu and Uju was tacitly about what makes something an illness, it was explicitly a debate about the role of culture in deciding. Mental health research has had much the same debate for at least a century now. Depressed mood happens everywhere. Whether depression as an illness is also everywhere is less clear. Depression has been called the single most fraught psychiatric diagnosis for cross-cultural study.[26] This is a strong statement, since they are all fraught.

Two main questions have animated this fraught inquiry. The first is whether depression is a "culture-bound" syndrome of the West.[27] A "culture-bound syndrome" is an illness only found in certain cultures. Examples include *koro*, found especially in parts of Asia; people believe their sex organs are retracting and will disappear; and *ataque de nervios*, common in some Latin American contexts, often showing uncontrollable shouting, and a sensation of heat rising in the chest, among other symptoms.[28] Depression, Ifemelu argued, was a North American culture-bound syndrome.

DEPRESSION IS A THING

情感I 行为

- 情绪低落
- 对事物失去兴趣
- 内疚
- 悲伤

-"过度"悲伤

- 预期会发生坏事 遐想 社交退缩 感觉自己毫无价值 有自杀倾向 注意力不集中 认知功能障碍 犹豫不决 烦躁失神（无法感受到快乐） 易激惹 无望 情绪不稳定 紧张/焦虑 经常哭泣 恐旷症 疑病症 存在感焦虑 低动机 情绪受抑制 感觉"空虚"。

精神病

- 妄想
- 极端偏执
- 想象中的贫困
- 幻觉

体感"

- 消化问题，包括胀气、便秘、胃痛

- 运动迟缓
- 失眠
- 性欲减退
- 食欲下降或增加
- 低垂的眼睛
- 低能耗
- 身体沉重感
- 月经减少或暂停
- 紧张，尤其是头部或颈部
- "针尖对麦芒"
- 心脏、胸痛
- 苍白
- 手心出汗
- 呼吸困难
- 头晕
- 口中的苦味
- 耳鸣
- 眼前出现黑暗或雾气
- 手脚冰凉
- 吞咽困难

本清单有许多空白。为了使清单尽可能全面 尽可能 我想 我 可能的冗余 这些症状也是 出现在 脑浆 或未被考虑的疾病" 男人 西米亚 在创作这首诗的时候。参见安德鲁 (重启 舒洽 我，史蒂夫 海涅 迈克尔-巴格比，"美国的文化冲突

- 其中一些是"反向体细胞"，即预期症状。例如，如果在过多的毫克会导致 是 0e 相反 的 症状。 入睡是一种身体症状、 睡觉 图 尝试 计算 抑郁症症状清单 在所有 过去和现在的背景，按领域分类

- Existential ang
- Low motivation
- Suppressed emotion
- Feeling of "emptiness"
- Tinnitus
- Experience of darkness or mist in front of the eyes
- Cold hands and feet
- Trouble swallowing

There are overlaps in this list. To make the list as comprehensive as possible, I deliberately included possible redundancies. Many of these symptoms are also features of other mental illnesses, or of illnesses that are not considered "mental." A similar list appears in Ryder et al. (2008); I drew on it while composing this one. See Andrew G. Ryder, Jian Yang, Xiongzhao Zhu, Shuqiaou Yao, Jinyao Yi, Steven J. Heine, and R. Michael Bagby, "The Cultural Shaping of Depression: Somatic Symptoms in China, Psychological Symptoms in North America?" *Journal of Abnormal Psychology* 117 (2008), 300–13.

[a] Some of these are "reverse somatic," meaning a symptom that is the opposite of the expected symptom. For example, if being unable to sleep is a somatic symptom, sleeping too much would be the reverse somatic symptom.

Figure 1 *A (futile) attempt at a comprehensive list of depression symptoms in all contexts, past and present, sorted into domains*

属于 在大多数 二十世纪 精神病学 to 详细 亚型、 尽管 他们更 强攻 在描述中 忧郁症。

With 所有变异 所示 图中 1, 我们真的在讨论 关于 the same 疾病 in 古往今来 and 地方? And yet, 那儿 are 人 普遍性: 的身体（大脑、 心 荷尔蒙 生殖器、 例如） and 经历 (饥饿、 高兴、 亲密、 悲伤、 敬畏等等）。他们 vary 形式上 文化、 但即使有巨大的 变异、 译文 横跨 文化 疆界 can 可能"。 实际上 凡人 社会 have 一个概念 精神 生病了 或疯狂"。 Does that 包括 匮 你有什 抑郁症? 怪 to 不符合"物理 病变" 测试。在没有 的清澈 物理 病变、 可能 普遍性 抑郁症 作为 疾病 也许 seem to 做 same 工作: 如果是疾病 无处不在 and 在任何时候 then 必须 真的是一种病-- 如果没有、 也许 似乎不那么真实。但在 越来越 问题 抑郁症的 普遍性 详细说明、a 警告: 这一标准 不再 断然 than 有形的 病变。 如果一种疾病只存在于特定的 地点和时间、 我们只能 结论 正是 那。 We 不能 结论 这是假的 ness.疾病 详细 to 文化 它们和其他任何东西一样真实。

of the clear physical lesion, the possible universality of depression as an illness might 他们是否 Have 抑郁症 无处不在? ss everywhere

如果 讨论 之间 伊菲梅卢 and Uju 被默认为 关于 what 使得 什么 一种疾病、 明确 辩 关于 文化的作用 在决定 心理 保健 研究 在许多方面 同一争论 for 至少一个世纪 现在沮丧 mood 会发生 到处都是 是否 洼地 疾病也无处不在 不太清楚。 抑郁症 has been 人称 the 单人 most 煞有介事 精神科 诊断 for 交叉 文化 研究"。 This 是一个强大的声明、 因为它们都充满争议。 Two main 问题 have 动画 this 煞有介事 询问。 The 第一次 是 洼地 是一种"文化束缚" 症候群 的 西"。 文化束缚 综合征" 是一个疾病 only 发现 在某些情况下 tures. 实例 包括 koro、发现 尤其是 部分 亚洲；人民 认为 他们的性器官 are 缩回 and 就会消失; and 匾额 de neruios, common 在某些 拉丁语美国 背景、 时常 显示 不可控制的 呐喊、 and 轰动 热量 上升的 在 胸部 其中 其他 症状"。 抑郁症 伊菲梅卢 有争议、 是北 美国 拘泥于文化 综合症

Ojd was tacitly about what makes something an illness, it was explicitly a debate about the role of culture in deciding. Mental health research has had much the same debate for at least a century now. Depressed mood happens everywhere. Whether depression as an illness is also everywhere is less clear. Depression has been called the single most fraught psychiatric diagnosis for cross-cultural study.[26] This is a strong statement, since they are all fraught.

Two main questions have animated this fraught inquiry. The first is whether depression is a "culture-bound" syndrome of the West.[27] A "culture-bound syndrome" is an illness only found in certain cultures. Examples include *koro*, found especially in parts of Asia; people believe their sex organs are retracting and will disappear; and *ataque de nervios*, common in some Latin American contexts, often showing uncontrollable shouting, and a sensation of heat rising in the chest, among other symptoms.[28] Depression, Ifemelu argued, was a North American culture-bound syndrome.

If depression is not a culture-bound syndrome, it may vary in form. This raises the second question is: Do some cultures express depression in a more physical way, and less in terms of mood – and if so, what is the ground for calling it "depression"?

My own view is, first, that depression is probably not confined to the West, though it does seem that Western medical culture may have been historically more preoccupied with it than some others. Second, it may not be so much Western culture in general that is distinctive, but psychiatry itself. Psychiatry is a cultural system, with a set of beliefs about depressive illness that are not universal, but growing more global in their influence every day.

Looking at how views of depression in Africa have changed shows how knotty these questions are. In the early twentieth century, in colonial Africa, Western psychiatrists said that depression was rare to non-existent. In the 1960s and 1970s, the early independence period, more cases were found, and some began to say rates were as high as in the West, or higher.[29] Rise in prevalence, better detection, or diagnostic drift?

Better detection played some role. Early reports came from asylums, who admitted people upsetting social order, not people with the social withdrawal or lethargy often found in depression. Colonial asylums were not for therapy. They were more like prisons for the mad. The numbers probably changed during independence because people started looking at suffering people in other contexts, out of asylums.

But racism also had a role in the low numbers found in the early reports. Claims that depression is uniquely Western are tied to the history of Western imperialism. During the Atlantic slave trade, European slavers created stereotypes of carefree Black people, immune from melancholy and mental illness.[30] These images co-existed with, and soothed, an awareness by slave owners and slave traders that slavery could cause severe melancholy. On slave ships, slave traders saw that among captives even in this horrific setting, extreme cases of melancholy stood out. The captors sometimes took some modest medical measures to address it.[31] The image of Africans as immune to depression remained sturdy, though. It served a purpose. It allowed a denial of the inhumanity of slavery by diminishing the full humanity of the enslaved. The image influenced later colonial observers, biasing them against

finding depression in Africa.[32] Depression, these observers thought, was not just an illness, but a *capacity* held by more civilized people. Mental illness was not alone in this prejudice. White physicians once thought cancer was rare among Black people because it was a disease of more advanced races.[33]

The idea that depression was rare in Black people survived into racist North American science well into the twentieth century. In 1914, a doctor at the Georgia State Sanatorium claimed that "The Negro mind does not dwell upon unpleasant subjects; he is irresponsible, unthinking . . . Depression is rarely encountered even under circumstances in which a White person would be overwhelmed."[34] A 1962 account of American Black people and depression shows the mental contortions racist science makes to avoid rethinking its assumptions. The report granted that there was no evidence of less depression in Black than White people. The authors then offered possible reasons why rates *might* be low among Black people anyway. Then, they used these speculations to confirm that the rates were indeed low![35]

While Western racism influenced the perception of depression, the question of its prevalence in Africa puzzled African observers, too. Nigerian T. A. Lambo, one of the first African psychiatrists, changed his mind, first thinking depression was rare, then wondering if it was being under-counted, and finally deciding it was being misdiagnosed.[36] Depressed patients, he decided, had been given a wrong label: neurasthenia. Neurasthenia was an illness made famous by American neurologist George Beard in the nineteenth century. Like depression, it had many symptoms, including depressed mood, mania, anxiety, irritability, impaired intellect, indigestion, malnourishment, insomnia, weakness, nerve pain, loss of faith, and fear of poverty.[37] Most of these symptoms could be a part of a depression diagnosis in current Western medicine. Depression, though, is classed as a mental illness that can have physical effects. Neurasthenia was the opposite: Beard thought it was a physical illness that could have mental effects. He thought it was a loss of nervous energy, and urged physical cures.[38] Neurasthenia started to decline as a diagnosis in the West in the early twentieth century, but went on to be used in African and Asian countries, and still is in some.

In the early 1960s, Lambo worked with an international team to compare concepts of mental illness among the Yoruba of Nigeria

12 如果抑郁症 不是一种受文化束缚的 综合症 其形式可能有所不同。
这就提出了第二个问题 是：有些文化 抒发郁闷
如果是这样，那么是什么原因造成了这种情况？
称其为"抑郁症"的理由是什么？
我自己的观点是 洼地 可能是 not 封闭的 to
西方、 尽管 看来西方国家 医疗 文化 可能有
历来 更专注 比 some 其他人 第二
也许没有那么多 西方 文化 一般来说 t~at 是 c1ist~nctiv~、
而是精神病学本身。精神病学 是一种文化 系统，有一套信念
关于抑郁疾病的知识并不普遍、 但不断增长 more 全球
每天都受到他们的影响。
寻找 如何看待抑郁症 非洲发生了变化 显示
how 疑难 这些 问题 are. In the 早 第二十 世纪、 in
殖民地非洲，西方 精神病学家 他说 洼地 是罕见的 to
不存在。 在 1960 年代和 20 世纪 70 年代，独立初期 期间、
发现了更多的病例，有些人开始说病例率高达 就像
西方、 或更高"。 发病率上升、 更好 侦测、 或诊断
tic漂移？
更好 检测 游戏 some 角色 早期 报告 came from asy-
灯泡 who 承认 人民 镦粗 社会 订购、 not 人民 with
社会退缩 或嗜睡 时常 发现 抑郁症。 殖民地时期
精神病院不是用来治疗的。它们 更像是监狱 为狂。
The 人数 也许 变了 期间 独立 因为 人民
开始关注苦难 其他 背景、 走出精神病院。 to
但种族主义也发挥了作用 在 人数少 发现 in the 早
报告声称抑郁症 是唯一的 西方 与他的
西方历史 帝国主义。 期间 大西洋奴隶贸易 欧洲
奴隶主 创建 定型观念 of 无忧 黑色 人、 免疫 from
懑 and 精神 病"? 这些 图像 共存 用、 and
安抚、 认识 奴隶主 and 奴隶贩子 that 奴隶制
会导致严重的忧郁症。 On 奴隶船、 奴隶贩子 看到
其中 即使在这个可怕的 设置、 极致 案件 黑色素
角质 站立 out. The 俘虏 有时候 took some 谦虚 医疗
应对措施 "。非洲人免疫的形象 抑郁症
仍然存在 不过很结实。 它是有作用的。 它允许 拒绝 的
非理性 ~通过减少 完整的人性 被奴役者。
The 受图像影响 之后 殖民地 观察员、 偏置 them 反对

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发现物 洼地 in 非洲"? 抑郁症 这些 观察员 以为、 3
was not just an 疾病、 but a 能力 held 更多 文明 人。
心理 疾病 没有 一个人 在这 偏见。 白色 医生 once
认为癌症在黑人中很少见，因为它是更先进种族的疾病。
, but a *capacity* held by more civilized people.
The 认为抑郁症 在黑人中很罕见 幸存 成种族主义者
北区 美国 科学 well into the 第二十 世纪。 In 1914, a
医生 在佐治亚 州立疗养院 声称 认为 黑人 mind
不谈论不愉快的话题；他不负责任，不假思索
... "抑郁症 很少遇到 即使在 情况 其中
白色 人品 就会 不堪重负 "14 1962 年的叙述 美国
黑色 人民 and 洼地 显示 the 精神 蠕变 种族 sci-
ence 使得 to 避免 反思 其假设。 The 报告 的确 a
that 那儿 was no 证据 of less 洼地 in 黑色 than 白色
人。 The 作者 then 提供 可能 原因 为何费率 也许 be
低 黑人 无论如何那么 他们利用这些猜测 to
确定 that 费率确实是 10w!
虽然 西方 种族主义受到影响 观感 抑郁症、 the
问题 of its 流行 在非洲 一脸茫然 非洲 观察员、 too.
尼日利亚 T. A.兰博 one 第一个阿夫提卡人 精神科医生、 变了
他的思想、第一想想 洼地 是罕见的、then 纳闷 如果是
作为 计算不足、 并最终决定 被误诊了"。
抑郁 病人 he 已决定 had been 考虑到 错 标签 neu-
伥偻病。 神经衰弱 was an 疾病 made 驰名 by 美国
神经学家 乔治 大胡子 十九世纪 世纪。 比如抑郁症、
it had many 症状 包括 郁郁寡欢 心情、 狂躁症、焦虑、
易怒、 ...受损的 智力 消化不良、 营养不良、 失眠、
软弱无力、胆子 痛 失去信仰，害怕贫穷"。 Most 其中
症状 可以 他是洼地的一部分 诊断 在当前 西方
药 抑郁症 虽然、 属于 作为精神 疾病 that can
有身体 效果 神经衰弱 而我却恰恰相反：大胡子的想法 it
是一种物理 精神疾病 效果他认为 它是一个
神经失常 能源、 并敦促 物理治疗"。 神经衰弱 开始
下降 作为诊断 在西方 二十世纪初 世纪、 hut
后来被用于阿夫提卡 和亚洲国家、 在某些情况下仍然如此。
对比 概念 of 精神 疾病 其中 the 伊博语 of 尼日利亚
In the 早 1960s, 兰博 工作过 with an 国际 team to

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with those in Western contexts. No Yoruba word translated exactly as depression.[39] Many symptoms of depression, though, came up in Yoruba accounts of distress. They included "sapped vitality . . . crying continuously, extreme worry, loss of appetite," and lost interest in life.[40] The research team didn't decide whether depression was a defined illness for the Yoruba, though they found depressive symptoms just as common as in the Western context. Many Nigerians continue to believe their country has no depression, that depression is a Western thing. Many are also challenging this view, though (see figure 2).[41]

The changing African figures show that debates about the rates of mental illness are never only about numbers. They are also about how definition, culture, and politics shape the collection of the numbers.[42]

Many languages, like Yoruba, lack a medical word for depression.[43] As Kenyan writer Ted Malanda wrote after actor Robin Williams's suicide, "I can't wrap my mind around the fact that depression is an illness. We are stressed and depressed all the time! In fact, it is such a non-issue that African languages never bothered to create a word for it. Anybody who knows what they call depression in their mother tongue, please step forward."[44] Does this settle the case? Maybe not. If a society lacked a specific word for malaria, and only had a word for fever, we would say they had malaria if we could find the microbe in them, even if they did not have the specific word. But depression has no specific microbe, and in the case of malaria, the person is considered sick. Do depressive symptoms only become an illness state if the society groups them into a diagnosis?

Ifemelu might say that this grouping happens because of the Western expectation of happiness. Societies that expect suffering from life might have depressive mood, but not the illness. This might, for example, include Buddhist societies. In Buddhism, the first of the four noble truths is that existence is suffering. Perhaps it makes no sense, in such a context, to call depression an illness.[45] If so, however, I do not see how any state of distress, whether mental illness, infectious disease, or chronic physical disease, could be an illness. Buddhist societies certainly have illness. Some Buddhist societies have also had long histories of seeing extreme sorrow, or loss of interest in life, as signs of illness.[46] So do other societies without a special expectation of happiness. In Iran, sadness is a mark of seriousness and maturity, but is separate from depression, the illness.[47]

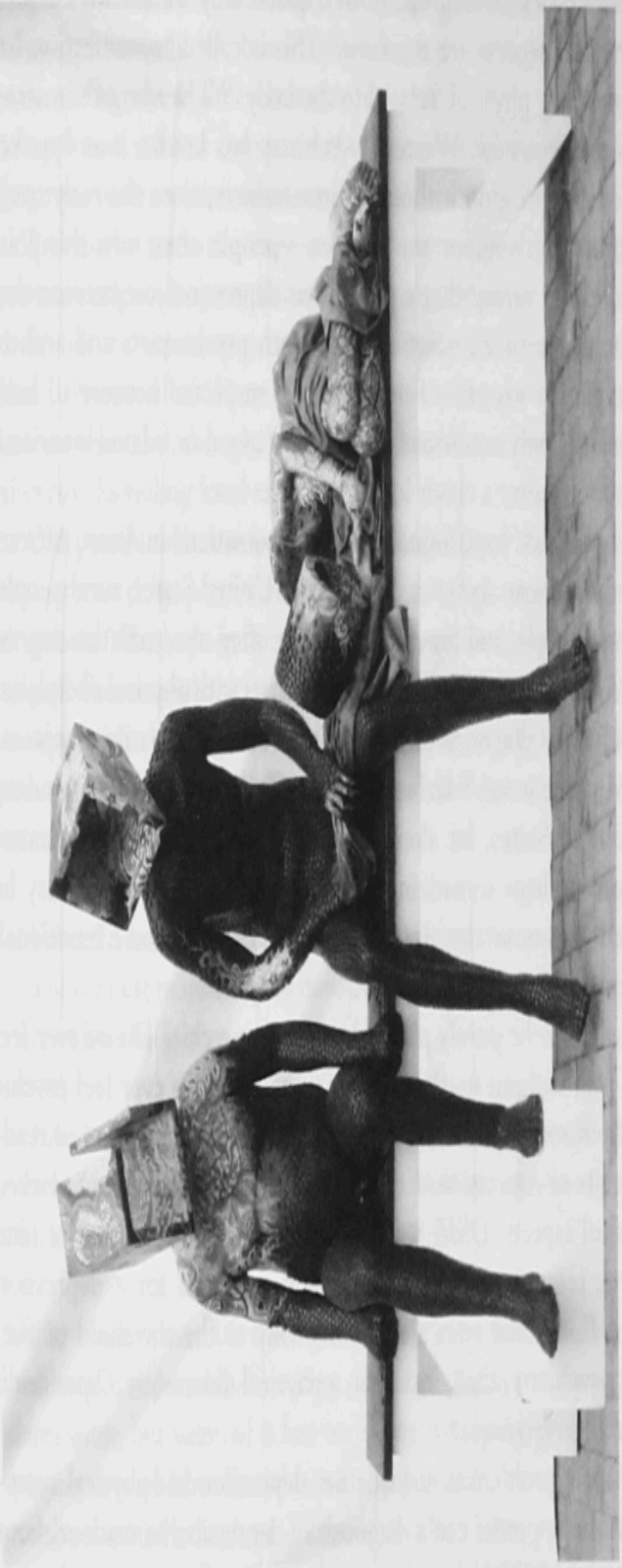


Figure 2 *This image was brought in to a class on depression by a Nigerian student. It's not clear that the artist meant to depict depression; the student said it represented depression to her*
Source: Peju Alatise, "The Unconscious Struggle."

with 西方国家 背景没有 约鲁巴语翻译 正是
抑郁症"。 许多抑郁症状 虽然、 came up in
伊博语 账户 的痛苦。他们 包括 "榨干 活力 ... 眼泪
不断、 极度担忧、食欲不振"。 失去兴趣 在生活中。
The 研究 team 没有 决定 是否 洼地 was 轮廓分明
约鲁巴人的疾病 尽管 they 发现 抑郁 症状 just
常见 如西方的 背景许多尼日利亚人 继续 to
认为他们的国家没有萧条，认为萧条 是西方
的事情。许多人还在挑战 虽然 见图 2)41
The 改变 非洲的数字显示 辩论 关于 the 费率 of
精神疾病从来都不仅仅是数字的问题。它们还关系到定义、文化和政治如
何影响数字的收集"。
as 许多语言，如约鲁巴语，都没有抑郁症的医学词汇"。正如
肯尼亚作家泰德-马兰达在演员罗宾-威廉姆斯去世后写道 自杀、
"我无法理解抑郁症的事实 是一种疾病。我们
总是感到压力和沮丧！事实上，这根本不是问题 that
非洲语言从未困扰过 为它创造一个词。任何人 who
知道什么叫抑郁症 在他们的母亲 舌头 请
ward,n-这能解决案件吗？也许没有。 社团 没有具体的
如果我们能在他们身上找到这种微生物，我们就会说他们得了疟疾，即使他们没有
have
这个词。但抑郁症 没有具体的 微生物、 而在
患疟疾者被视为 有病。怎么抑郁 症状 only
如果社会 组别 诊断? uicide,
伊菲梅卢可能会说，这种分组 会发生 因为西方
预料之中 的幸福。 期待痛苦的社会 生活可能
有抑郁症 心情、 但不是 the 疾病。 This 可能、 for 例如
包括 佛教徒 社会 在佛教中、 the 第一次的 four 贵
真理就是存在 是痛苦的。 也许 它使 没道理 在这种情况下
a 背景、 称抑郁症 病"。 如果是这样 I do not see
how 任何国家 的痛苦、 是否 精神 疾病、 传染病 疾病、
或慢性 物理 疾病、 可以 是一种疾病。 佛教徒 社会 cer-
当然有病。一些佛教团体 也有悠久的历史
看见 极致 悲伤、 或失去兴趣 在生活中，作为迷惘疾病"。
你也一样其他 社会 不带 特别 预料之中 of 幸福。 In
伊朗，严肃的标志 和成熟、 但又是独立的 from
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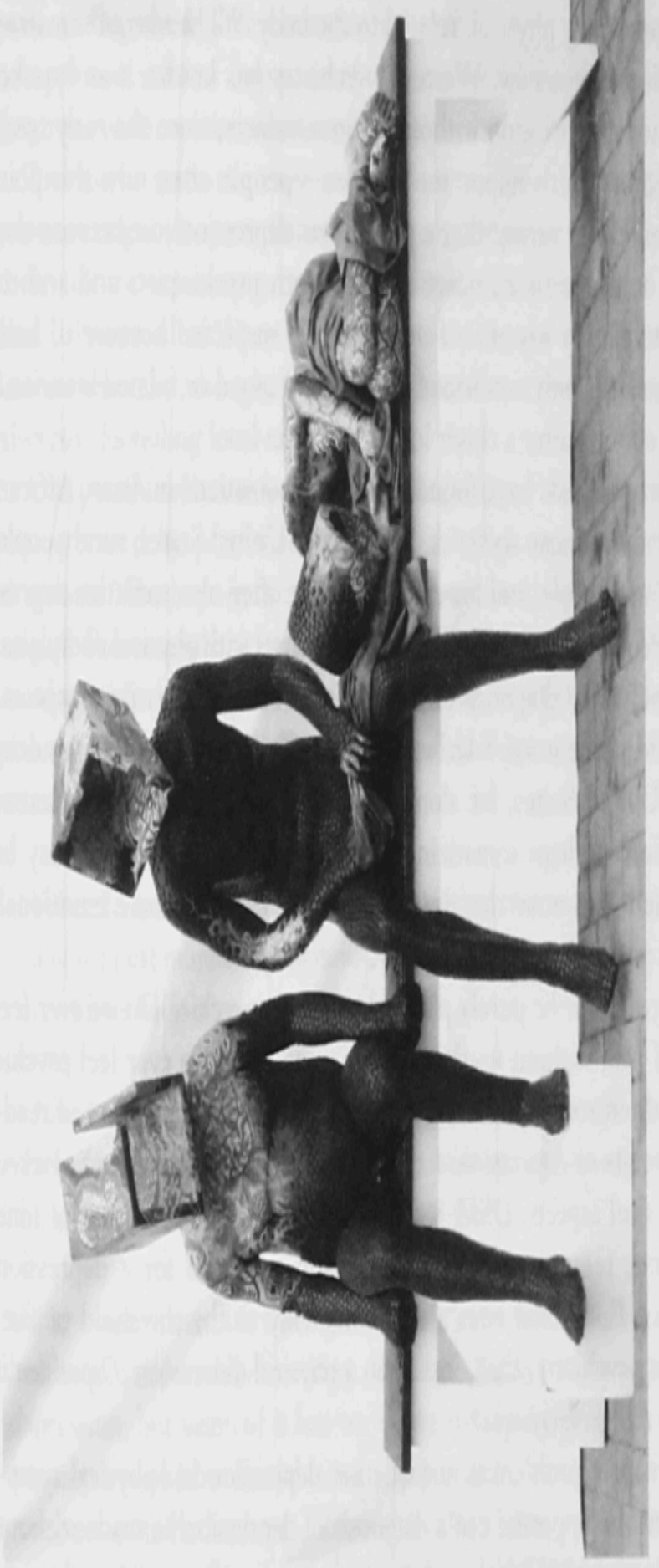


Figure 2 *This image was brought in to a class on depression by a Nigerian student. It's not clear that the artist meant to depict depression; the student said it represented depression to her.*
Source: Peju Alatise, "The Unconscious Struggle."

Sorrow and loss of interest are emotional signs. Depression has physical signs, too, and cross-cultural debate has also asked whether any apparent lack of depression in a place only means that depression's physical aspects are the focus. This is called "somatization," to make something physical, related to the body.[48] The idea of somatized depression is not new. Western psychiatry has known it as "masked depression," depression without obvious sadness, since the early twentieth century.[49] It's important to stress – people often miss this point – that no one is saying that a person has depression just because they have a backache or an upset tummy. Both psychiatrists and anthropologists usually say that if depression is suspected because of body problems, it is only confirmed if depressed mood or related emotional signs are found after a closer look.

Anthropologists have found depression somatized in Asian, African, and Latin American societies.[50] But in the United States, rural people, non-White people, and lower-class people often also somatize depression.[51] People come to primary care physicians with physical complaints and leave with a diagnosis of depression if other depressive symptoms are found in the exam.[52] Urban, White, affluent people are a minority in the United States, let alone globally. If so many places somatize depression, perhaps somatizing is the norm. The term itself may be misguided. It assumes that the primary state of depression is emotional, and the physical aspects secondary.

Can pain ever be purely physical or purely psychic? Do we ever feel physical pain without it affecting our minds? Do we ever feel psychic pain without some sensation in our bodies? After many years of reading accounts of depression, I recall none where the depression lacked any physical aspects. DSM 5, with its requirement of five out of nine symptoms, requires at least one somatic symptom for a depression diagnosis. Emotional ones alone won't tally to the threshold of five. Western psychiatry, then, insists on a physical dimension. *Depression is always a bodily experience.*[53]

The harder problem is not whether depression has physical symptoms, but the opposite: can a diagnosis of depression be made without signs of sadness? Without sadness, a depression diagnosis may stretch the term until it becomes incoherent.[54] Perhaps later evidence could confirm depression. One psychiatrist gave the example of a woman

who complained only of headaches, and then hung herself.[55] The psychiatrist inferred depression from the suicide. Another psychiatrist had patients with symptoms including anorexia, insomnia, impotence, and menstrual irregularity, but little evidence of sadness.[56] Some of the patients improved after electroconvulsive therapy. If a patient with no apparent sadness improves after a treatment for depression, is a diagnosis of depression warranted?

Treatment gives the cross-cultural questions practical urgency. It seems wrong to deny a suffering person a treatment that works because their culture expresses or names the suffering differently. Concerns about the spread of Western psychiatry as a form of cultural imperialism are also valid, though. Using labels from one culture in another one always risks veiling local experience.[57]

One possible solution is to use local categories, or "idioms of distress," that are used by particular cultures, instead of supposedly universal diagnoses. The hope is to capture nuances of meaning in different settings.[58] For example, a Punjabi idiom called "sinking heart" has some overlap with the English word "depression," including weakness and unhappiness.[59] Physically, "sinking heart" manifests in the chest. In the words of afflicted people:

> When I have sinking heart my heart goes fast. One minute it goes up and the next minute it goes down. It is as if my heart is shrinking and my whole body is going wrong.
>
> I used to get this in my heart all the time and it felt like shaking . . . or shrinking . . . in my heart. This feeling made me walk up and down. I could not sit still and I felt great agitation.[60]

Other expressions of sinking heart include dry mouth, faintness, headache, and trouble breathing. Some of this picture is suggestive of depression, but some of it less so. If you simply call it depression, you lose aspects of how Punjabis see the problem. Their medical model revolves around the heart. The heart distributes food, breath, and blood, and is a reservoir for emotions and drives. Western psychiatry roots emotion more in the brain. Loss of control of the heart is loss of control of the self for Punjabis. This loss of control can happen when

悲伤 and 失去兴趣 are 情绪化 迹象。 抑郁症 has 物理 迹象、 和跨文化 讨论 还 要求 是否 任何明显的 不抑郁 一处 only 办法 that 匮 s 这就要求我们把注意力集中到社会的物质方面。这称为 "躯体化" to 有所作为 身体，与身体有关。[48] The 躯体化的概念 洼地 不是 新。西部地区 精神病学 已知 作为"蒙面 抑郁症"。 洼地 不带 明显的悲伤，因为早期 双 tieth 世纪"？这很重要 强调-- 人民 时常 怀念 点 没有人说一个人 有抑郁症 就因为 they 腰酸背痛 或不高兴 肚子 Both 精神病学家 and 人类 物理学家 通常说 如果抑郁症 怀疑 因为 "身体的 问题 只证实 如果抑郁 mood 或相关 情绪化 仔细观察后会发现一些迹象。

人类学家 发现抑郁症 酸化 在亚洲、 非洲人 和拉丁美洲社会。但在美国 各州、 农村 人、 非白人 和下层 人民 时常 也会抽筋 匮 "。 人们来找初级保健医生看病，是因为身体 投诉 并被诊断为抑郁症 如果其他 抑郁 症状 是在考试中发现的"。 城市 白色、 富裕 人民 是少数 在 联合 各州、 遑论 全球。 如果这么多 名额 筋化 抑郁症、 兴许 筋膜化 是 标准。 The term 它本身 may be 误导。它假定抑郁症的主要状态是情绪，而身体方面则是次要的。

疼痛是否可以纯粹是身体上的或纯粹是 灵媒？ 我们是否曾感到 身体上的痛苦，而不 影响 我们的思想？ 我们是否 通灵 不痛 一些感觉 在我们的身体里？之后 many 岁月 的读数 账户 抑郁症、 我记得没有 其中 the 洼地 匮 任何身体方面的问题。DSM 5 的要求 的五分之一 九个 症状 需要 至少 one 体感 病状 for 坳陷 诊断。 情感 单个 不会 统计到 门槛 五个。 因此，西方精神病学坚持认为抑郁症是一种生理疾病。抑郁症是 a/ways a bodily experience. The 更难 问题 不在于 洼地 具有物理 共鸣 但情况恰恰相反： 能否诊断 抑郁症 制成 不带 悲伤的迹象？没有 悲伤 诊断 会伸展 该词 直到 它变得 语无伦次。[54] 也许 之后 证据 可以 确定 抑郁症。 One 精神病学家 给了 范例 of 女

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[56] Some of the 患者 改进 后 电休克 治疗 如果病人 with no 明显的 悲伤 改善 后 待遇 for 抑郁症、 is a 诊断 抑郁症 有正当理由吗？ 治疗 给 the 跨文化 问题 实用的 紧迫性。 It 好像不对 茹苦含辛 人品 待遇 因为 他们的文化 表示 or 姓名 the 忧患 不同的是 关注问题 关于 差价 西 精神病学 作为形式 文化 御 不过，"文化"一词也有其合理性。在另一种文化中使用一种文化的标签总是有可能掩盖当地的经验。[57]

一种可能 解决方案 是使用本地类别、 或"危难成语"， that are used by 详细 文化、 而是 据称 万有 诊断。 The hope 就是要捕捉 细微差别 意义 在不同的 set- 环"。 For 例如 旁遮普人 习惯用语 称 "沉 心" 有一些 复 with the 英语 word "抑郁症" 包括 无力 and 不快乐"。 身体方面 "沉 心" 舱单 在胸部。在 话语 受苦的 人：

When 我的心在下沉，我的心跳得很快。前一分钟还在上升 下一分钟 我的心在往下沉。好像我的心在缩小，又好像 我的整个身体都出了问题。

以前我的心里总是有这种感觉，就像在颤抖..... or 缩水 ... 在我心中。这种感觉让我上气不接下气。I 我坐立不安，感到非常激动。

其他 表达 of 下沉 "心灵 包括 "dry 嘴巴 晕厥、 头疼 and 麻烦 呼吸 Some 这张照片 令人联想 of 抑郁症、 但有些 的情况就不那么严重了。如果简单地称之为抑郁症、you lose 方面 如何 旁遮普人 参见 问题 他们的 医疗 模型 旋转 围绕 the 心 The 心灵 分销 食物 呼吸、 and 血液，是情感和驱动力的储藏库。西方精神病学更多地将情感根植于大脑。失去对心脏的控制 控制权 旁遮普人的自我。 This 失控 会发生 when

and the next minute it goes down. It is as if my heart is shrinking and my whole body is going wrong.

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people pay too much attention to their emotions.[61] By contrast, many Americans might say you "lose yourself" when you pay too *little* attention to your emotions.

When symptoms in local idioms overlap a lot with those of depression, it's possible that the idioms capture local ways of thinking about depressive illness more than they show absence of depression. One idiom of distress found in numerous places translates as "thinking too much."[62] In some contexts, this idiom does not look much like depression, but in many others it does. Perhaps many of the languages without a word for depression are calling it "thinking too much."

Referring to depression as a "Western" illness raises other problems. What even is "Western culture"? American society has numerous sub-cultures, and depression patients do not share the same concepts of sickness, even if they are evaluated using the same manual. Europe is a multicultural continent, with differences in how low affect and distress are seen.[63] And what are the boundaries of "the West"? Much of the tradition regarding melancholia during classical antiquity was adopted by Islamic writers during the Middle Ages. The great Persian scholar Avicenna had a section on melancholia in the *Canon of Medicine* (completed in the eleventh century). Like much of classical antiquity, this tradition was transmitted to Europe during the Renaissance.

One thing *not* at stake, to me, in the depression and culture debates is the realness of depression. Culture-bound illnesses are as real as any other. We often treat things that are (in the tired academic phrase) "socially constructed" as less real. But our houses, tax codes, and the internet are "socially constructed." They are not found in nature before human action, but they are real.[64]

Arguments for the absence of depression, anywhere, pose the question of whether one was looking in the right way. Arguments that depression is universal pose the question of whether the suffering could be better captured in local terms. One thing is certain, though: depression is fast becoming a universally-used label. As the reach of Western psychiatry grows – to the point where it might be better called "cosmopolitan psychiatry" – people all over the world are using its language to understand distress.

Cultural differences concern more than the existence of or rates of

depression. Western psychiatry often treats anxiety and depression as separate things that often occur together.[65] In many places, though, anxiety and depression are seen as part of one thing.[66] Cultures also differ in how they explain depression. In the West depression has recently been treated as an illness with physical causes, such as genes or neurochemistry. Critics point out that this can cover up psychological and social aspects. Most cultures do not do this, though. Globally, it is more common to consider depression to be at once psychological, social, and physical.

The model of depression in Western psychiatry is not best seen as a norm from which others depart, but as a set of cultural assumptions of its own. Western psychiatric views of depression stick out in four ways. First, Western psychiatry emphasizes emotional over physical symptoms. Second, it separates anxiety and depression.[67] Even in the West, the separation of anxiety and depression is new.[68] Third, Western medical tradition has stressed the proportionality criterion. Most cultures consider hardship in life an obvious cause of depression. Fourth, even though Western psychiatry highlights mood over physical symptoms, it ironically puts unusual stress on physical *causes*, at least in recent decades.[69] The Western stress on individual biology treats suffering individuals apart from their social context. Globally, depressive illness is usually considered something that happens because of social conditions, not something caused mainly by biology.

As Western psychiatry's assumptions and practices spread globally, we may see important gains and losses. One gain may be the spread of effective treatments outside their culture of origin. To the extent, though, that the conception of depression is biological and individualistic, socially sensitive views may be lost.

The question of the newness of depression poses similar challenges. Some believe clinical depression has been around for all of human history. One Assyriologist, struggling with depression herself, sees evidence for her ailment in texts from the ancient Middle East that are thousands of years old.[70] Perhaps the guilt-ridden despair that disabled King Saul in the Hebrew bible was clinical depression.[71] Many historians in recent years stress instead the ways depression is a new illness category.[72] The argument for newness can also sow doubt about the

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reality of the illness. It shouldn't. Depression can be new and culture-bound and still be an illness.

Is It a Gift?

When aunt Uju pushed the illness label, she did not think she was describing a gift. Some though, believe that for all the wretchedness of depression, it confers certain assets. Lots of creative people in history seem to have had depressive symptoms. Abraham Lincoln's melancholy may have added to his political gifts, by helping him to understand other people better.[73]

Three questions caution against making a grand conclusion about this. One, how many other illnesses have a lot of gifted people had? If any illness is common, a lot of the people who get it are going to be gifted. Second, how many people with depressive symptoms were *not* especially creative, and we have never heard of them, because they had no special gift? Third, how many creative people were lost to history because depressive illness kept them from using their talents?[74] Depression may shape the kind of creativity a person has, but I doubt that it gives more creativity.

Creativity aside, some say that people with depression have a better grasp of reality.[75] In research this is called "depressive realism." As Susanna Kaysen, the author of *Girl, Interrupted* puts it, "My main objection to optimism is that it's incorrect. Things are somewhat more likely to turn out badly."[76] Some depressed people do say they value the insight the illness yielded. If this is a gift, it comes with a curse.

Mind and Body

Repeat as Necessary: Biological and Psychological Models Are Complementary, Not Incompatible.

Far too many people have tried to argue that depression is purely biological, or purely psychological. Biological understandings of depression do not prove that psychological or sociological understandings are wrong. Psychological and sociological understandings do not undermine biological understandings.

The media will often report new research showing that genes, or

inflammation, or gut bacteria, or some other biological factor causes depression. However good this research is, it is not inconsistent with psychological approaches. The inflammation might be caused by stress. Or, genes may create a vulnerability that is pricked by personal history. When put that way, doesn't it seem obvious? Yet many say, in response to new research on biological factors, "well, there goes Freud!" This is a logical fallacy. Put another way, it is wrong. Biological and psychological models are complementary, not incompatible.

Apart from cause, depression always has psychological content – problems in families, or work, obsessive thoughts, etc. Psychology can have insight into these problems, no matter how much biology may have caused the illness. Biological and psychological models are complementary, not incompatible.

A biological treatment can work, even if the cause of illness isn't biological. Efficacy of electroconvulsive therapy, antidepressants, or other physical treatment does not allow firm conclusions about cause. A treatment of the brain can work for a problem with a psychological origin. Biological and psychological models are complementary, not incompatible.

People can benefit from physical and psychological treatments at the same time. Antidepressants and psychotherapy have greater efficacy when combined, for example.[77] They may act on different aspects of the problem, but that may be exactly why they are most effective together – different aspects of the problem require different work. Biological and psychological models are complementary, not incompatible.

Let's look at two memoirists of mental illness, Kay Redfield Jamison and Elyn Saks.[78] Jamison suffers from bipolar disorder, Saks from schizophrenia. Jamison and Saks both came to appreciate that their illnesses were both psychological and physical.

Jamison began having extreme mood swings as a young adult. She was hesitant about medication – the illness had elevated states she did not want to give up. After facing the wreckage of excessive spending and self-destructive behavior several times, she came to see that the medicine was essential, life-saving. As a scientific researcher on bipolar disorder herself, Jamison is steeped in the genetic science of the illness. Neither this, nor her reliance on medication, stopped her from finding insight-oriented psychotherapy helpful for her recoveries.

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Jamison 拥有 极致 mood swings as a young adult. She was hesitant 关于 medication – the illness had elevated 国家 she did not want to give up. After facing the wreckage of excessive spending and self–destructive behavior several times, she came to see that the medicine was essential, life–saving. As a scientific researcher on bipolar disorder herself, Jamison is steeped in the genetic science of the illness. Neither this, nor her reliance on medication, stopped her from finding insight–oriented psychotherapy helpful for her recoveries.

problem, but that may be exactly why they are most effective together – different aspects of the problem require different work. Biological and psychological models are complementary, not incompatible.

Let's look at two memoirists of mental illness, Kay Redfield Jamison and Elyn Saks.[78] Jamison suffers from bipolar disorder, Saks from schizophrenia. Jamison and Saks both came to appreciate that their illnesses were both psychological and physical.

Jamison began having extreme mood swings as a young adult. She was hesitant about medication – the illness had elevated states she did not want to give up. After facing the wreckage of excessive spending and self-destructive behavior several times, she came to see that the medicine was essential, life-saving. As a scientific researcher on bipolar disorder herself, Jamison is steeped in the genetic science of the illness. Neither this, nor her reliance on medication, stopped her from finding insight-oriented psychotherapy helpful for her recoveries.

As a law student, Saks began to have scary psychotic episodes. She sought the help of psychoanalysis, which she found helpful in decoding the source and meaning of her delusions. She was resistant to drugs, however, fearing they would suggest that she was *really* ill in a way that she did not want to be. The psychoanalysis did not do enough. Like Jamison, she accepted drug therapy, with some resignation. The combination of treatments, together with strong social supports, enabled her to become a law professor. The efficacy of the psychoanalysis was not enough to keep her from trying drugs. The efficacy of the drugs did not lead her to abandon her support for psychoanalysis, and she became a psychoanalyst herself. The importance of the social supports did not lead her to discount or discard her need for medical treatment.

The evidence that depression has both biological and psychological dimensions is so vast it is beyond questioning. For all the enigmas that surround the ailment, one proven thing is that it is not entirely mental or physical. The only thing strange about this is how people struggle to see it. Efficacy of physical treatments for depression never seems to sway people skeptical of them, who continue to insist that psychotherapy or social reform is the only way forward. Nor does the efficacy of psychotherapy, or our knowledge of the social causes of depression, seem to sway many who reduce depression to biology.

Reductionists of various kinds have had their day, especially over the last century. Depression is a complex problem. It has multiple causes – which makes it unlikely only one kind of response will do.

This is a way depression does differ from melancholia. The medical ideas underpinning the idea of melancholia were never just mental or just physical. They assumed mind and body constantly influence one another. How did we lose that?

As a law student, Saks began to have scary psychotic episodes. She sought the help of psychoanalysis, in which she discovered a helpful aid in decoding the true meaning of her delusions. She resisted drugs. However, her colleagues suggested that she was ill, which she did not like to hear. Her psychoanalysis did not do enough. Like Jamison, she accepted treatments, together with strong social supports, enabled her to become a law professor. The efficacy of the (一)..... The psychoanalysis was not enough to keep her from trying drugs. The efficacy of the drugs did not lead her to abandon her supportive psychoanalysis, and the drugs did not lead her to abandon her supportive psychoanalysis. The drugs did not lead her to abandon her supportive psychoanalysis. She became a psychoanalyst, and she does not regret it. The social support did not lead her to reject or abandon her need for treatment. The evidence for depression is beyond questioning. For all the enigmas that surround the ailment, one proven thing is that it is not entirely mental or physical. The only thing strange about this is how people struggle to see it. Efficacy of physical treatments for depression has never seemed to stir many people skeptical of them, who continue to insist that depression is a mental or physical illness. The only thing strange about this is how people struggle to see it. Efficacy of physical treatments for depression has never seemed to stir many people skeptical of them, who continue to insist that depression is a mental or physical illness. Nor is it clear how our understanding of the last century's economic woes would be helped by a reductionist view of depression. Depression is a complex problem. It has multiple causes, which makes it unlikely only one kind of response will do.

This is a way depression does differ from melancholia. The medical idea of melancholia was never just mental or physical. Its basic premise was that mind and body were always interacting. How did we lose that?

As 一个法律专业的学萨克斯开始 to have 可怕的精神病 插曲
她寻求 the help 精神分析 其中 she 发现 有帮助 ain
解码 本义 她的妄想。 She 有抵抗力 ll
毒品、 然而 惧怕 他们会 建议 that she was 的确 ill
这是她不愿意看到的。她的 精神分析 did not do
够了 就像贾米森 她接受了 药物治疗、 with some 辞职
(一)..... The 组合 of 治疗、 在一起 with 坚强 社会
支持、 启用 她成为 一位法学教授。 The 功效 的
精神分析 没有 足够 以保持 her from 难 毒品 The
药物的疗效并没有使她 摒弃 her 支持 心理学
她成为了一名精神分析师 她自己 The 重要性
社会支持 并没有使她打折扣 或丢弃 her need
接受治疗。

The 抑郁症的证据 既有 嗨学 and 心理
标定尺寸 浩瀚无垠 质疑。 For 所有 谜团
环绕 疾病、 一个行之有效的事情 那就是 不是 完全
精神 或有形的。"(《世界唯权宣言》) 奇怪 关于 this 是如何 人民
奋斗 to see it. 功效 of 物理 疗程 for 洼地
似乎从未动摇过人们的怀疑态度 的、 who 继续 要坚持
that 精神疗法 or 社会 革 是 only way 前进。 Nor
是否 心理治疗的疗效、 or our 知识 of the 社会
抑郁症的成因，似乎动摇了许多将抑郁症归咎于生物学的人。

这就不可能只有一种回应 就可以了。

这是一种抑郁症 确实不同于忧郁症。 The 医疗
基本思想 忧郁症的概念 were 从不 just 精神 or
只是身体上的。他们认为精神和身体一直在相互影响。 我们是如何失去这一点
的？ .