Beyond Blue

What is depression?

By Jacob Sullum

Good Mood: The New Psychology of Overcoming Depression, by Julian L. Simon, La Salle, Ill.: Open Court, 307 pages, $52.95/$18.95 paper

Listening to Prozac, by Peter D. Kramer, New York: Viking, 409 pages, $23.00

I get depressed on Sundays. I'm not sure exactly why. Maybe it's emotional conditioning, the anticipation of work, or the burden of free time. Maybe it's a biochemical phenomenon. Whatever the cause, I tend to feel unaccountably sad on Sunday afternoons.

No big deal. But if you knew a way to avoid the Sunday-afternoon blues—say, an attitude adjustment or a handy little pill with no unpleasant side effects—I'd be interested.

Julian Simon also used to be depressed on Sundays—and every other day of the week. This *was* a big deal. As the distinguished University of Maryland economist describes it in *Good Mood*, he was depressed "for 13 long years from early 1962 to early 1975. When I say that I was depressed I mean that, except for some of the hours when I was working or playing sports or making love, I was almost continuously conscious of being miserable, and I almost continuously reflected on my worthlessness. I wished for death, and I refrained from killing myself only because I believed that my children needed me....Endless hours every day I reviewed my faults and failures, which made me writhe in pain. I refused to let myself do...pleasurable things...because I thought that I ought to suffer."

Simon's problem and mine are obviously quite different. Indeed, according to the definition of *depression* that he uses—prolonged sadness, accompanied by feelings of low self-worth, helplessness, and hopelessness—my experience does not even qualify. It is merely "the garden variety of the blues that come and go in a day or a week."

Still, Simon's overwhelming, 13-year-long depression and my mild, occasional dysphoria are both cases of mysterious sadness with a variety of possible psychological and biological explanations. And both might respond to psychotherapy or drugs. Simon, in fact, overcame his own depression through the cognitive-therapy methods he describes in his book. These techniques, which focus on changing self-destructive ways of thinking, are intended for people who are depressed in the noncolloquial sense. But they probably could do some good for just about anybody who suffers because of unreasonable self-criticism. Simon's approach certainly appeals to me as a way of dealing with everyday problems of living, although I have never experienced anything approaching the ordeal that he went through.

Simon did not try anti-depressant drugs, but he writes that "I...probably would and should have tried such drugs during my long depression if they had been as well-established as they now are." Prozac, the anti-depressant that psychiatrists are most enthusiastic about these days, was not available until December 1987. Since then it has helped many severely depressed people escape psychological states as bad as or worse than Simon's. And as psychiatrist Peter D. Kramer details in his thoughtful, elegantly written book, *Listening to Prozac*, even mildly depressed people like the drug, which has few significant side effects. (An appendix to the book persuasively debunks reports of suicides and murders allegedly caused by Prozac.) Kramer describes several individuals, active and productive but vaguely unsatisfied, who found they enjoyed life more while taking Prozac. Psychiatrists generally do not prescribe Prozac for the Sunday-afternoon blues, but who knows? It might just do the trick.

The apparent versatility of cognitive therapy and Prozac suggests that deep, incapacitating depression sits on the same continuum as the chronic blahs and the periodic blues. If so, psychiatrists have some explaining to do. A continuum view of depression raises uncomfortable questions about their scientific claims and legal privileges.

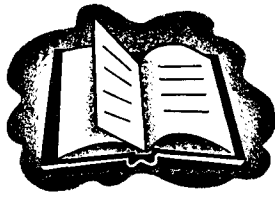
Both Simon and Kramer call severe depression a disease. For Simon, this label is largely metaphorical. He speaks of controlling the "symptoms" of depression (which he agrees anti-depressants can do), as opposed to curing the "disease" itself (which he thinks requires psychotherapy). But in describing the various factors that might lead to depression, Simon gives little weight to biology. For Kramer, depression seems to be an illness in the same sense that cancer is; it can be traced to a physical abnormality, whether in the structure of the brain or in the production and use of neurotransmitters and hormones.

A continuum view of depression is not necessarily inconsistent with the notion that severe depression is a disease. Diabetes and hypothyroidism, for example, are matters of degree; in these and other cases, doctors have to decide, somewhat arbitrarily, when an organ's functioning is far enough from the norm to constitute an illness. But depression is different from such conditions in a crucial respect: No one can identify the physical defect that supposedly underlies it. As Kramer admirably demonstrates, people can and do *speculate* about a biological mechanism. In the end, however, they have to admit (if they are honest) that no one really knows how depression works or what causes it.

Kramer offers a great deal of intriguing speculation about the

biological roots of both depression and personality. The main effect of Prozac, for example, is to boost the level of the neurotransmitter serotonin in the synapses between brain cells, suggesting that a deficiency of serotonin leads to depression. But there are problems with this hypothesis: Some depressed people do not respond to Prozac, and some respond to drugs that do not act on serotonin. Anti-depressants that raise serotonin levels do so within hours, but people who take them generally do not feel an effect for weeks.

"Biologists do not know what depression is," Kramer concedes. "The reigning model at the cellular and chemical level, the biogenic-amine hypothesis [tying depression to shortages of serotonin and norepinephrine], is demonstrably false or incomplete. Understanding of minor mood disorders, or normal variants, is even more primitive....About affective and social temperament, the experts know least of all....The biological study of the self is so primitive as to be laughable."



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In light of this ignorance, does it make sense to call depression a disease? Thomas Szasz and other critics of the medical model have long complained that psychiatrists tend to view every thought, emotion, and behavior they do not like as the symptom of a hypothetical illness. Although he is by no means ready to join the dissenters, Kramer, too, seems troubled by this tendency. The qualms surface in his discussion of Prozac's impact on personality.

Kramer reports that a sizable minority of depressed people who take Prozac undergo marked personality changes. One of his patients, for example, "became less bristling, had fewer rough edges." He also lost interest in pornographic movies, which he had long insisted that his wife view with him. Another felt less serious about life and less driven to self-sacrifice for the sake of others. A third overcame lifelong shyness and began to date regularly. Kramer finds these changes vaguely disturbing, and much of his book is an attempt to identify the reasons for this unease.

Kramer notes that Prozac can alter a person's self-concept, so that she feels "normal" under the drug's influence and "not herself" when she stops taking it. Such people retain the memories they've always had (as well as the unchanged aspects of their personalities), and in this sense their identities remain intact. Nevertheless, individuals transformed by Prozac raise some interesting questions about the nature of the self. Of course, they are hardly unique in this respect. Long before the advent of modern anti-depressants, the reformed drunk, the religious convert, and Ebenezer Scrooge raised similar questions.

But Kramer worries that drugs like Prozac will expand the bounds of psychiatry and medicine to include treatment of conditions that heretofore have been viewed as personality traits. "Confronted with a patient who had never met criteria for any illness, what would I be free to do?" he asks. "If I did prescribe medication, how would we characterize this act?...Now that questions of personality and social stance have entered the arena of medication, we as a society will have to decide how comfortable we are with using chemicals to modify personality in useful, attractive ways. We may mask the issue by defining less and less severe mood states as pathology, in effect saying, 'If it responds to an anti-depressant, it's depression.' Already, it seems to me, psychiatric diagnosis has been subject to 'diagnostic bracket creep'—the expansion of categories to match the scope of relevant medications....How large a sphere of human problems we choose to define as medical is an important social decision."

Kramer is right to be concerned, but the way he frames the issue reveals some assumptions that are worth questioning. He identifies the development of Prozac-like drugs as the crucial step down the slippery slope toward universal mental illness. Nowhere in the book does he address psychiatry's conceptual leap from physical diseases with mental manifestations, such as syphilitic insanity, to the unproven assertion that certain emotions, thoughts, and behaviors are caused by underlying diseases. So long as this can simply be assumed, psychiatrists are free to define anything they want as illness, including shyness, nervousness, oversensitivity, obnoxiousness, and various bad habits. Check out the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, and you will see that Kramer's vision of arbitrary medicalization has already come to pass.

It is not much of an improvement to say that a condition should be called a disease only when it has something to do with biology, or when it can be affected by drugs. Everything we think or feel—including envy, bigotry, and murderous rage—is presumably associated with phenomena in the brain. Many substances, including legal and illegal recreational drugs, can affect such psychological states. But that does not mean these thoughts and emotions are symptoms of diseases. It is certainly possible to accept the notion that mind and body interact without concluding that every negative result of that interaction should be treated by a physician.

When Kramer says that "we as a society" will decide which problems should be considered medical, he must mean himself and the rest of the APA. After all, it is psychiatrists and other physicians who are legally empowered to control access to Prozac. This is the source of Kramer's dilemma: To prescribe or not to prescribe? If people were free to ingest whatever chemicals they wanted, with or without expert guidance, each deci-

sion would not require a determination of what constitutes illness.

Most Americans are uncomfortable with the idea of pharmacological freedom. It's one thing to take Valium for anxiety disorder or Prozac for depression; those are accepted medicines for recognized diseases. It's quite another to smoke pot to relax or inject heroin to make a miserable life bearable. Kramer is perceptive enough to sense that this may be a distinction without a difference. He wonders how using Prozac to enhance someone's social life "could be distinguished from, say, the street use of amphetamine as a way of overcoming inhibitions and inspiring zest. ...People take street drugs all the time in order to feel 'normal.' Certainly people take cocaine to enhance their energy and confidence." Once you grant the validity of this analogy, it's hard to justify the double standard created by drug prohibition on the one hand and mandatory prescription on the other. Why should people have to beg permission when they want to alter their consciousness?

Prozac could enhance individual autonomy by giving depressed people another option for improving their lives. Yet it could also enhance the power of the medical establishment, making people more dependent on physicians.

Unlike Prozac, Simon's approach to depression does not require clearance from an M.D. Indeed, he urges readers to try out his techniques on their own, consulting a therapist or counselor only if they feel it's necessary to get started. Purchasers of *Good Mood* can even receive a free copy of a computer program that is designed to help reveal the aspects of their thinking that get them into trouble.

Building on the work of cognitive therapists such as Albert Ellis and Aaron Beck, Simon offers a plausible analysis of the psychological mechanism behind depression. He focuses on the idea of negative self-comparisons, in which the individual contrasts what he takes to be his current situation with a benchmark state. When someone frequently makes such comparisons, Simon says, he will tend to be sad. If he also feels helpless to change his situation, he will be depressed.

Simon offers a number of ways to escape depression, all of which require self-discipline, thorough introspection, and hard mental work. The first step is to make the negative self-comparisons explicit. Then they can be attacked from a variety of angles: Are the depressed person's perceptions accurate? Can she change her current situation? Is the benchmark she is using appropriate? How important should a given self-comparison be to her happiness? Can she train herself to make different comparisons or to make them less frequently? Can she draw on deeply held values to make the self-comparisons seem less significant?

Simon's approach will not appeal to everyone. Some will consider it too rational, too mechanical, or simply too difficult. But Simon's own experience and those of others who have used his methods, coupled with research on cognitive therapy generally, suggest that many people could benefit from the techniques described in *Good Mood*. Certainly his confidence that "you have the power to alter your mood by changing your current patterns of thought" is inspiring, especially given his own success.

Both Kramer's emphasis on Prozac and Simon's emphasis on Self-Comparisons Analysis might seem to imply that depression is a uniform phenomenon with the same cause in every case. But a close reading of the two books reveals that a host of factors—including inherited temperament, childhood experiences, recent events, habits of thought, moral values, fatigue, and health problems—might play a role in depression. A flow chart in the back of *Good Mood*, difficult to follow even though it is "stylized and simplified," suggests the complexity of the problem.

Although Simon is pushing the advantages of cognitive therapy and Kramer is relating the wonders of Prozac, each grants that the other's approach has a place. Simon says anti-depressants can be useful as a stopgap measure, though not as a long-term solution. Kramer acknowledges that cognitive therapy works for some people, and he says "psychotherapy remains the single most helpful technology for the treatment of minor depression and anxiety." The two authors also agree that dredging up the past may be unnecessary. Both Prozac and Self-Comparisons Analysis deal with a depressed person's current state of mind, regardless of how he got there.

Kramer, who offers counseling in addition to dispensing drugs, suggests how the psychological and biological approaches to depression might be reconciled: Whatever your inborn propensities, experience affects the structure and functioning of your brain. At least some of those changes can be reversed or compensated for either directly (through drugs) or indirectly (by altering your thinking). In this light, Kramer's pharmacotherapy and Simon's Self-Comparisons Analysis may be two sides of the same mind-body coin.

It's clear how Simon's approach empowers the individual. But Prozac, too, could enhance individual autonomy by giving depressed people another option for improving their lives. Given the current legal and cultural climate, however, it probably will also enhance the status and power of the medical establishment, making people more dependent on physicians. "To the extent that medications are important agents of personal transformation," writes Kramer, "change becomes ever less a matter of self-understanding and ever more a matter of being understood by an expert." Whether Prozac and future drugs like it ultimately have a liberating or enslaving impact may hinge on who controls them. ■

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Paragons Or Pariahs?

Arguing with Asian-American success

By John J. Miller

Asians and Pacific Islanders in the United States, edited by Herbert Barringer, Robert W. Gardner, and Michael J. Levin, New York: Russell Sage Foundation, 384 pages, $42.50

The Asian American Movement: A Social History, by William Wei, Philadelphia: Temple University Press, 355 pages, $34.95

Making and Remaking Asian America Through Immigration Policy, 1850–1990, by Bill Ong Hing, Stanford: Stanford University Press, 340 pages, $45.00

Chinatown: A Portrait of a Closed Society, by Gwen Kinkead, New York: HarperCollins, 215 pages, $12.00 paper

Asian Americans: Oral Histories of First to Fourth Generation Americans, by Joann Lee, New York: The New Press, 235 pages, $11.95 paper

A recent *Los Angeles Times* poll asked Asian Americans in Southern California about their job opportunities and living conditions. Eighty-three percent described them as good or very good, compared with 77 percent of whites, 55 percent of Hispanics, and 33 percent of blacks. Little wonder. Their satisfaction springs from many sources. Asian Americans have the highest median household income, the highest percentage of managerial and technical jobs, the lowest unemployment rate, and the lowest crime rate of any racial or ethnic group in the country, including whites.

As entrepreneurs, they have reinvigorated dozens of urban areas. Their achievements on the education front are epic. In college student lingo, MIT is now "Made in Taiwan" and UCLA is the "University of Caucasians Lost Among Asians." New immigrant waves make these gains increasingly visible—Asian Americans are the country's fastest growing racial or ethnic group. They currently make up 3 percent of the general population, including 10 percent of California's. Who can really doubt that Asian Americans have "made it" in America?

These purported accomplishments threaten to throw the country's black-and-white race debate out of kilter. In reaction, Asian-American civil-rights leaders try to debunk the Asian-American success story. Anti-Asian sentiment is on the rise, say the critics, from auto assembly lines in Detroit to the Broadway hit *Miss Saigon*, in which characters refer to Asians as "slits" and "greasy Chinks." Economic indicators touting Asian-American success are misleading: Per-capita income has always lagged behind that of whites, professionals hopelessly bang their heads against a glass ceiling, and many inner-city merchants, especially Koreans, now face an increasingly hostile clientele resentful of their prosperity. The "model minority" myth, which promotes Asian-American achievement, covers up genuine problems in the community and serves merely to pit racial and ethnic groups against each other. As an oppressed minority, Asian Americans both need and deserve the same special governmental protections accorded to other disadvantaged groups.

There are elements of truth to both of these views, but neither is completely accurate. Asian Americans are neither paragons nor pariahs, to use Smith College sociologist Peter Rose's apt terminology. For the real scoop on the state of Asian America, turn to the Russell Sage Foundation's excellent *Asians and Pacific Islanders in the United States*. The best recent demographic overview, it makes a strong case for Asian-American success without overlooking genuine problems.

With all the talk about the model minority, it's easy to forget that there's really no such thing as an "Asian American." Chinese, Filipinos, Japanese, Koreans, Asian Indians, Vietnamese, and others share no common tongue, faith, or history. Enormous differences in education, employment, and income separate these groups. To assume Asian Americans have a pan-ethnic identity—as politicos and professors do when it's to their advantage—is often futile and misleading.

Some Asian ethnic groups certainly do make the United States look like a land of unlimited opportunity. The mostly native Japanese-American population, for instance, seems "to have reached essential parity with whites." The largely refugee Vietnamese-American population, on the other hand, displays "characteristics more typical of 'castelike' minorities—blacks, American Indians, and Hispanics." Many differences exist even within ethnic groups. East Coast Filipinos look like a socioeconomic elite; on the West Coast, they more closely mirror Hispanics. The reverse is true for Chinese.

Nonetheless, it's hard to argue with success, no matter how generalized it may be. Asian Americans can boast of extraordinarily stable families, very little divorce, and high levels of education. Most (but not all) of their per-capita income disadvantage can be explained by immigrant status. Whatever troubles remain—even for the problematic Southeast Asian cohorts—