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The medicalisation of misery: A critical realist analysis of the concept of depression

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Abstract

This paper will explore some difficulties with the concept of depression from the perspective of critical realism. We have three aims. First, we will describe the variable, and sometimes incommensurable, ways in which the diagnosis of depression has been defined and discussed in professional mental health texts. Secondly, we will examine this confusion in relation to historical and cross-cultural work on emotions and distress. Thirdly, we will provide two case studies from social science which reveal the limitations of conventional approaches to depression – the research of George Brown and Lyn Abramson and their co-workers.

Introduction

Recent debates about psychopathology are characterised by two polarised positions. The first of these might be described as 'medical naturalism' and the second 'social constructionism'. Medical naturalism, following Kraepelin, assumes that psychiatric nosology proceeds incrementally with a confidence that there exists a real and invariant external world of natural disease entities (Hoff, 1995). The logic of this position is that these entities are studied by diagnosticians with increasing sophistication, leading to a more and more accurate description of reality. A variety of critics have argued that the absence of hard signs in psychiatry renders all of its functional diagnoses (i.e. most of the work of the profession) as problematic or mythological (e.g. Szasz, 1961; Ingleby, 1981; Boyle, 1990). In the second position, following Foucault and Derrida, psychiatric diagnoses are studied as representations of a variegated and ultimately unknowable human condition. Mental illness, according to this approach, is a by-product of the activity of mental health professionals (Parker *et al.*, 1995). According to this view, causal arguments about mental health or illness are seen as inherently problematic, and the study of psychopathology 'itself' is replaced by a study of the ways in which psychopathology is represented or socially constructed. Within medical sociology, constructionist critiques have also been evident about non-psychiatric illnesses (Bury, 1986) although, as with functional mental illness, there has been a tendency to focus on conditions with contested or unknown aetiology, such as multiple sclerosis.

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It is possible to take a third approach, which in some respects lies between these oppositional points of debate. This position, which can be called 'critical' or 'sceptical realism' (Bhaskar, 1990; Greenwood, 1994), shares with social constructionism the requirement that scientific and technical concepts be examined in the context of the social and historical conditions which allowed them to emerge. However, in contrast to the social constructionist approach, it does not assume that the study of psychopathology itself must give way to the study of discursive practices alone. Rather, the study of the social and historical context of concepts is seen as an indispensable strategy for replacing biased or misleading concepts with ones which are more useful scientifically and clinically. In a critical realist account it is not *reality* which is deemed to be socially constructed (the axiomatic radical constructionist position), rather it is *our theories of reality*, and the methodological priorities we deploy to investigate it. Our theories and methods are shaped by social forces and informed by interests. These include interests of race, class and gender as well as economic investment and linguistic, cultural and professional constraints in time and space. These forces and interests invite forms of sceptical or critical analysis when we are asked to accept or reject empirical knowledge claims about reality. Thus deconstruction has a part to play in this exercise, but human science should not be reduced methodologically to this position alone. We can, and should, make attempts at investigating reality in itself, but do so cautiously and critically.

In this paper we illustrate this approach by offering an exploration of emotions and emotional distress, focusing on the way in which the concept of depression has been employed in psychiatric theory. It is striking that psychiatric texts, despite asserting knowledge about 'affective disorders' in general and 'depression' in particular, rarely include discussions about the general nature of emotions (Power & Dalgleish, 1996). Even within psychology texts, when the emotions are addressed, discussion about their nature usually occurs in separate chapters from discussion of psychopathology. We will argue that the incoherence of many psychiatric accounts of depression becomes understandable when this literature is examined.

Professional representations of depression

Within the psychiatric and clinical psychology literature, there are a variety of positions taken about what constitutes depression. In some texts, no working definition is offered at all, although a range of symptoms are explored. This approach is evident in the writings of some biological theorists (e.g. Golden & Janowsky, 1990) as well as some who are more psychologically orientated (e.g. Beck *et al.,* 1979). This failure to provide a clear definition implies that the concept of depression has a self-evident validity. However, closer inspection reveals that different authors assign primacy to different psychological phenomena when writing about depression. For example, some texts insist that it is primarily a disturbance of mood and that all associated phenomena are secondary to this affective state (Lewis, 1934; Becker, 1977). Others focus primarily on cognitive features. Perhaps most influential in this latter respect has been Beck and his colleagues, who have argued that the depressive experience is characterised by a negative view of the self, the world and the future (Beck *et al.*, 1979).

In an attempt to avoid assigning primacy to one particular feature of depression some writers have argued that depression is a 'Syn-

drome not a symptom and this syndrome requires the presence of several symptoms' (Montgomery, 1990, p. 31). In accord with this assumption, DSM-IV (American Psychiatric Association, 1994) requires the presence of depressed mood and four other symptoms before 'major depression' can diagnosed. Other psychiatric definitions include looser or more arbitrary inclusion criteria. For example, in one standard text it is stated that:

> In the clinical context the term depression refers not simply to a state of depressed mood, but to a syndrome comprising mood disorder, psychomotor changes and a variety of somatic and vegetative disturbances. All of these changes may be present *but none including depressed mood is essential...* (Willner, 1985, p. 3, emphasis added).

In another text it is stated that, 'The word depression is used in many ways to describe a mood, a symptom, a syndrome... as well as a specific group of illnesses...' (Mendels, 1970, p.1). Moreover, following the presentation of a list of symptoms, the text goes on to observe that:

> The extent to which these symptoms are present and their combination are infinitely variable: other symptoms are frequent and sometimes dominate the clinical picture (Mendels, 1970, p. 6).

A similar 'anything is possible' position can be found in accounts written by psychologists. For example, Davison & Neale (1990) provide a symptom checklist of nine points blended from the American Psychiatric Association sources but then go on to note that a '...single individual seldom shows all the aspects of depression; the diagnosis is made if at least a few signs (*sic*) are present...' (p. 207).

Of course, it is common in physical medicine to find groups of patients with the same physical dysfunction (disease) who none the less report a range of experienced symptoms (illness). However, the diagnostic approaches to depression outlined above differ from those in physical medicine in at least two important respects. First, there appears to be no consistent transcultural, transhistorical agreement about minimal necessary and sufficient pathognomic criteria for the phenomenon of interest. For this reason, depression, like other functional psychiatric diagnoses such as schizophrenia (Bannister, 1968; Bentall *et al.*, 1988), is a disjunctive concept, potentially applicable to two or more patients with no symptoms in common. Secondly, as in the case of other psychiatric diagnoses, the diagnosis of depression is based exclusively on symptoms and not on signs. If it was possible to redefine depression in terms of unambiguous biological markers it would be possible to distinguish between those who were *really* depressed and those who just appeared to share some experiences in common with depressed people. Of course, in redefining depression in this way, there would be a danger that the clinical concept of depression would become entirely divorced from the everyday concept of depression. However, this danger is not imminent because biological markers are *ipso facto* missing for all functional diagnoses, including that of depression.

Drawing the line between depression and other phenomena

One consequence of the ambiguity about what constitutes depression is a series of important disagreements about the dividing line between depression and other kinds of psychological states. For example, some authors regard depression as a categorical concept, whereas others regard it as existing on a continuum with normal functioning. Taking

the first of these approaches, Murphy (1982) notes that true 'clinical depression' in the elderly may be difficult to distinguish from more common dysphoria. In contrast, some cross-cultural psychiatrists have argued that each culture has varying criteria for describing everyday misery and distinguishing this from abnormal unhappiness (e.g. Klienman, 1988). It appears that psychologists are more prone to assume the continuous distribution of personality features and psychological functioning, including the depressive experience (e.g. Eysenck, 1977), whereas psychiatrists are more likely to argue that illness is a category or discontinuous state (e.g. Kendell, 1975). These biases probably reflect the professional socialisation of each group – psychologists operate statistical assumptions about experience and behaviour, whereas medical practitioners are taught to distinguish normality from abnormality by emphasising diagnostic criteria. A fundamental basis of the social status of medical practitioners is their unique claim to diagnostic rights. Accordingly, it is rare for doctors to abandon or problematise the latter. Similarly, psychologists accrue social status by their applied scientist role and so require a scientific rhetoric (about statistical reasoning) to maintain their professional mandate (Pilgrim & Treacher, 1992).

The relationship between depression and anxiety is just as contentious as the relationship between depression and normal functioning. In some texts, depression and anxiety are regarded as having such a common co-presence that a mixed group of symptoms from each 'condition' come to constitute a single pathological condition. For example, the tenth edition of the International Classification of Diseases (ICD-10) describes a mixed anxiety depression syndrome (World Health Organisation, 1992). Psychiatric texts about primary care work also point to the common occurrence of this mixed condition (Montgomery, 1990). Some authors have therefore argued that the 'neurotic' forms of depression cannot be distinguished from other neurotic disorders (Tyrer, 1990) or that it may be most useful to speak of a general neurotic syndrome that can be manifest with varying degrees of depression or anxiety (Goldberg & Huxley, 1992). Researchers using factor analysis have sometimes attempted to resolve these disputes by classifying pathological emotional states in ways which differ markedly from ordinary language usage. For example, Clark & Watson (1991) have proposed a model which divides negative emotions into three factors: non-specific negative affect, manifestations of somatic tension and arousal and anhedonia and the absence of positive mood.

There are also disputes about the dividing line between depression and madness. It is usually assumed that affective states can become psychotic if sufficiently severe, in which case they are accompanied by 'lack of insight' or other psychotic phenomena such as delusions and hallucinations. Kraepelin held that these psychotic forms of depression were distinct from dementia praecox (later renamed schizophrenia) and proposed the term manic depression to describe both psychotic unipolar depression and depression accompanied by episodes of mania, now known as bipolar disorder (Goodwin & Jamison, 1990). However, this distinction was soon challenged by some authors who argued that mixed conditions are common and who suggested that the term 'schizoaffective' might be used to describe such mixed states (Kasanin, 1933). DSM-IV (APA, 1994) distinguishes between schizophrenia, schizoaffective disorder, major affective disorder and bipolar affective disorder, each of which is divided into further subtypes. Although the term 'bipolar affective disorder' implies that mania lies at the

opposite end to depression on a spectrum of affect, phenomenological studies indicate that manic patients report negative mood as much as positive mood (Goodwin & Jamison, 1990).

Finally, there have been disputes about the relationship between depression and physical disease. Textbooks of psychiatry often point to the somatic features of depression (e.g. loss of weight, fatigue, loss of appetite), thus allowing the possibility of attributing these symptoms to depression in the absence of overtly negative mood or cognitive features. This ambiguity about the central role of somatic symptoms in depression is most evident in the debates which have surrounded the nature of 'chronic fatigue syndrome' (CFS) – formerly known as 'post-viral syndrome' or 'myalgic encephalomyelitis'. Some authors have entirely rejected the view that CFS is even, in part, a psychological phenomenon (Ramsay, 1986). Others have seen it as a form of hysteria or masked depression (McEvedy & Beard, 1970), whereas others have argued that it is caused by physiological dysregulation which, none the less, is affected by some of the processes thought to affect depression. (For a review of the diverse competing theories about shared, separate and direction of etiology, in CFS and depression, see the Joint Royal Colleges Report (1996).)

Given these confusions about its nature and boundaries, it is perhaps not surprising that Seligman (1973) has described depression as, 'The common cold of psychopathology, at once familiar and mysterious'. This description, while reflecting the fact that depression is the most common diagnosis assigned in psychiatric practice, acknowledges that the term belongs both to the technical vocabulary of the mental health professions and also, like the common cold, to ordinary language. In order to understand the existing confusions, therefore, it is essential to know how both the professional and lay concepts of depression have emerged from their cultural contexts.

Historical, cross-cultural and intra-cultural aspects of affect

The psychiatric concept of depression has its roots in three separate diagnoses which have now faded from the professional discourse. The first was melancholia (a form of lunacy) and another was neurasthenia (nervous exhaustion). During the nineteenth century, a third notion, 'mopishness', was also found in common parlance along with melancholia, but was primarily attributed to the lower classes (MacDonald, 1981).

The rise of depression as a single term for negative emotional disturbance followed the demise of its three predecessors. Until the Napoleonic wars melancholia was: 'but a rag-bag of insanity states whose only common denominator was the presence of few (as opposed to many) delusions' (Berrios, 1995) but, by the mid-nineteenth century, it had been transformed into a disorder of the emotions characterized by inhibition and a decline in function. The concept of 'mental depression' was introduced at this time as an analogy with 'physical depression', a term used to describe a decline in cardiovascular function. Its dominance was assured by the later dissolution of 'neurasthenia' following the theoretical challenges created by shell-shock during the Great War (Stone, 1985). This precursor of the currently preferred 'post-traumatic stress disorder' subsumed a variety of symptoms including 'hysteria', 'anxiety states', 'neurasthenia', 'disordered action of the heart' and 'shell-shock' itself (putatively caused by the neurological trauma of exploding missiles).

Although modern Anglo-American psychiatrists consider neurasthenia to lack con-

ceptual validity, the concept is still used in China, reflecting cultural differences of opinion about the relationship between somatic illness and depression (Kleinman, 1988). To take another example of these differences, in some parts of the Indian sub-continent misery is often expressed through reports of a fallen or painful heart. This observation has led western psychiatrists to claim that these patients are 'really' suffering from depression and that they are mistakenly siting their grief behind their sternum. By contrast, medical sociologists studying distressed Asian patients point out that depression is a recent Western medical representation, which has no inherent conceptual superiority to that of alternative descriptions of unhappiness from other cultures (Fenton & Sadiq, 1991). Apart from the cognitive preferences and interests of Western medicine reifying concepts such as 'depression', its diagnostic concepts are shaped and reinforced by drug company marketing and research strategies. This point is made with specific reference to 'depression' by Healy (1997) and highlights one of our introductory points that economic forces at times may shape concept formation and retention.

The problem of psychiatric diagnosis in different cultures can be understood by looking to more general cross-cultural studies of affect. Different societies using different languages use a wide but variable range of words to describe emotional states. Wallace & Carson (1973) found over 2000 words describing emotions in English, although less than 200 are found in the vocabulary of most people. By contrast, Lutz (1980) found only 58 words used by the Ifalukians of Micronesia to refer to transient internal states. Howell (1981) found that the Chewong of Malaysia have only seven words which translate into English as emotional states. Russell (1991), in a large review of ethnographic studies of emotions, found that some states which are described regularly by English speakers have no analogue in other cultures. For example, in some African languages, the same word covers what would be described separately as 'anger' and 'sadness' in English (Leff, 1973), whereas the Gidjingali aborigines of Australia do not discriminate 'fear' and 'shame'.

Prototypical emotions which play a central role in western descriptions of psychopathology may be entirely absent in other cultures. Thus Marsella (1981) found no word for 'depression' in many non-western cultures and Leff (1973) found no words equivalent to 'anxiety' among Eskimos or Yorubas. Even when equivalent words do exist in two separate cultures, which might point to similar meanings (e.g. Japanese words for 'anxiety' and 'depression'), studies using word association or semantic differentials suggest that these experienced meanings are not always equivalent (Chan, 1990). In his review, Russell (1991) concluded that we cannot even take for granted the pancultural meaning of facial expressions. Japanese and American subjects agree on 'surprise' or 'sadness' but not on 'anger' or 'fear'. Sometimes poor agreement is even found about which internal states are *emotional*. For example, the Japanese word 'jodo' has been translated as the equivalent of the English word 'emotion' (Matsuyama *et al.*, 1978) but the range of states it describes in Japanese includes English equivalents of 'lucky', 'motivated' and 'calculating'.

Russell's review of a range of ethnographic studies suggests that in a minority of cultures there is no collective word for 'emotion' and that most cultures have idiosyncratic emotional descriptions. For example, the English speaker has no immediate empathy for, and, no precise translation of, the German notions of *angst* or *schadenfreude* (hence our neces-

sity to retain the words untranslated). Similarly an Arab speaker may not understand the notion of *frustration*. Some cultures have many variants of one emotion (they are 'hypercognized' (Levy (1984)) compared to other cultural lexicons. By contrast a culture may have only one word for an emotion (it is 'hypocognized').

These studies beg the question of whether there are *any* grounds for making a claim for universal emotional states. It could be argued that cross-cultural differences are so great that this task is doomed. However, some methodologies, such as multi-dimensional scaling, point in a limited way to the existence of universal affective states. In this method, informants are asked to rate the similarity of a range of emotion words. Ratings are then analysed using a statistical procedure which tries to account for them in terms of a minimum number of dimensions. This method has been used to identify a broad two-dimensional model of universal emotions, 'pleasure versus dysphoria' and 'arousal versus sleepiness' (Russell, 1980; see Figure 1). This two- dimensional model also seems to produce consistent judgements about emotional states reported in photographs of facial expressions from varying cultures, including North America, Greece, Spain, Vietnam, Hong Kong and Haiti (Russell, 1991).

From these observations it can be concluded that social constructionism is correct to emphasize the cultural and historical relativism of first-person accounts of emotional states, but is incorrect when problematising all empirical claims about invariance in the reality and causality of mental distress. Equally, medical naturalism is correct to place an emphasis on empirical investigations of distress but incorrect in naïvely confusing culturally and historically specific professional concepts (in this case 'depression') with invariant templates of reality. The map is never the territory and, in the particular case of 'depression', the map is extremely unclear.

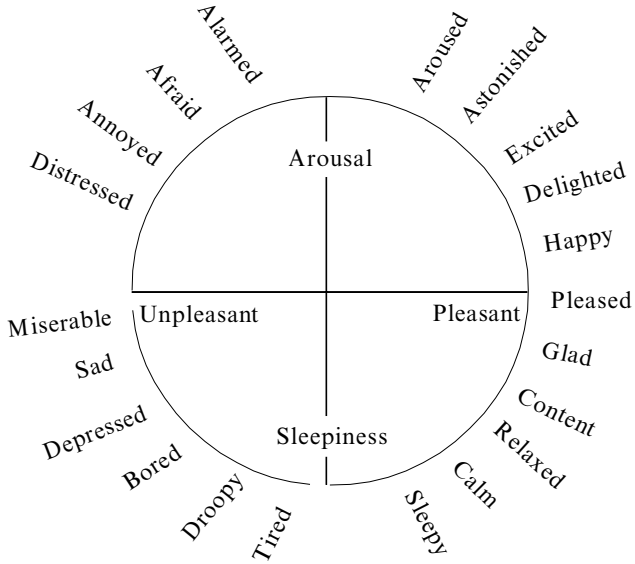

Figure 1: The emotional circumplex

Differences between professional and lay accounts of depression

These cultural findings, together with the inconsistencies in the way that the term 'depression' has been used by professionals, suggest that professional and lay uses of the term 'depression' differ in a variety of ways (Pilgrim & Rogers, 1993, Ch. 1; Rogers & Pilgrim, 1997). Thus we have a second major problem about the search for a universal lexicon of emotions – we cannot even assume consistency of meaning *within a culture,* particularly when a restricted professional code is used about abnormal emotional life by mental health experts. Similarities and differences between the two groups can be suggested as follows:

1. Professionals often assume that trans-historical and trans-cultural consistencies exist about mental illness whereas lay people *express* themselves about ordinary feelings and distress in a way which varies both across and within cultures.
2. Professionals claim a general pre-eminent and superior epistemological status for their descriptions. Lay people do not aspire to this pre-eminent position although they may expect that their idiosyncratic experience is taken seriously. The status of professionals is therefore bound up with their competence at generating expert accounts which are meaningful and transparent enough to be persuasive, but not so transparent that lay people can readily capture professional authority.
3. The social setting of professional diagnoses is not typical of the social settings in which emotions are experienced and emotional distress generated. A point diagnosis is a snapshot taken at one moment in a clinical setting using a type of lens owned by the diagnostician. By contrast a lay person's experience of distress occurs within the context of their unique biographical frame of reference and might be construed with reference to various aspects of their current, past or future life situation.
4. Professional accounts cannot be generated without reference to lay accounts about emotional distress. Lay people take up a range of views about professional expertise from trusting dependency to critical opposition. In between, some lay people may understand, accept and partially internalise the professional discourse (a phenomenon de Swaan (1990) describes as 'protoprofessionalisation'). Because terms such as 'depression' co-exist in both professional descriptions and in the vernacular, culturally specific representations of distress are sustained by the interaction between the discourses of lay people and professional healers. Analogously, as Kleinman (1988) observed, Chinese psychiatrists eschewed the diagnosis of depression in favour of neurasthenia just as much as their patients.

Thus, confusion about the concept of depression within the psychiatric literature reflects a tension between lay experiences of emotions (which have *both* trans-culturally recurring *and* biographically unique features) and professional accounts. Whereas lay accounts of distress have specific parochial and temporal value for ordinary people, they do not aspire to universalise their particular attributed meanings. In contrast, professional accounts assume the universal (i.e. transcultural and transhistorical) validity of their representations of misery (such as'depression'), an assumption that, on reflection, may seem unwise.

This conflict between professional and lay accounts is likely to be particularly problematic in the context of research into emotional problems. When potential patients state that

they are 'depressed', they are presumably evoking the lay representation of depression because it best fits their subjective apprehension of their position on the emotional circumplex. For example, they may feel dysphoric and to some extent either aroused (agitated) or sleepy (lethargic). Their self-report will also be influenced by the extent to which their cultural representation of depression is concordant with other aspects of their current experience – for example, feelings of low self-esteem or a lack of interest in events which would otherwise be pleasurable. To the researcher, this report of 'being depressed' is translated into the professional representation of a discrete and universal emotional condition – a *diagnosis* of 'depression'.

Brothers (1997), a neuroscientist who has been sensitive to these kinds of difficulties, has recently shown how the assumption of transculturally and transhistorically valid discrete emotional states has led to confusion in her field. She has argued that researchers have differed in their attempts to implicate particular structures in the limbic system in particular emotions, according to the different behaviours (elicited by brain stimulation or eliminated by ablation) which they have singled out as representative of those emotions. She has also pointed out that the changes in emotional behaviour observed in animals following brain stimulation or ablation depend on the social context in which the animal is placed. Finally, she has argued that many of the assumptions apparently supporting the more general hypothesis that the limbic system is the neurophysiological locus of emotion (that there are clear anatomical criteria for assigning structures to the limbic system; that these structures are exclusively involved in visceral regulation; that visceral changes are the basis of emotion) do not survive scrutiny. In her account, physiological researchers have been unable to achieve a more sophisticated understanding of the limbic system because they have accepted a naïve naturalist account of emotional states.

It seems likely that research in psychopathology will have been affected by similar difficulties. In the remaining sections of this paper we discuss two influential lines of research in which we believe these difficulties are evident.

The work of George Brown and colleagues on the social origins of depression

The work of George Brown and his colleagues has produced a highly sophisticated social model of 'depression', which subsumes a multi-factorial picture of past and present determinants within specifiable inter-personal, as well as, social situations. However, Brown has quite self-consciously evaded any pre-empirical consideration of the legitimacy of the diagnostic category of depression (see Brown & Harris, 1978, p. 20) and has made it clear that he believes that there is a biological substrate to an identifiable and diagnosable psychiatric condition which is different from everyday misery – 'depression'.

Brown's work can be situated within a Durkheimian tradition of sociological positivism which is highly compatible with medical naturalism. Ingleby (1981) describes Brown's work as a version of 'weak positivism' because of its uncritical retention of a dubious diagnostic category, despite its exploration of the meanings-in-context of distressed people. As a consequence of this, it fails to engage with the conceptual problems we have highlighted earlier, or with the points about cultural and historical relativism legitimately raised by social constructionists. (Brown and his colleagues are still working

on cross-national comparisons in which they export assumptions about the universal applicability of western psychiatric nosology.) Paradoxically, the very determinants the Brown model enumerates, which provide empirical evidence for the social causes of misery, may be obscured by emphasising depression as a 'real' medical condition. Indeed, the medical diagnostic approach to depression individualises the very social processes and antecedents the model quite persuasively explores.

Brown's work is most illuminating if the focus of attention is shifted from his chosen end-point (the diagnosis of depression) to the antecedent and situational factors which attend human misery. These have both political and psychological dimensions. For example, the inadequacies of male partners as sources of nurturance for women, and the tendency of the former to entrap and humiliate the latter, may create what Brown calls 'depressogenic' effects (Brown *et al.*, 1995). However, this could be reframed by simply stating that miserable women live with oppressive men. Similarly, sexually abused children are likely candidates for the later psychiatric diagnosis of depression (and others) (Browne & Finkelhor, 1986), with these victims constituting up to half of the psychiatric population. Given this linkage, while it is possible to talk about 'the diagnosis of childhood sexual abuse' and 'the diagnosis of depression' in its survivors, it is less mystifying to think about the enduring misery created by the sexual oppression of children by adults.

The work of Lyn Abramson and colleagues on attributions and depression

Attributional theories of depression have evolved from earlier animal models, in particular Seligman's (1975) learned helplessness theory, which argued that depression occurs when individuals have no control over their environment. Like much of the neurophysiological research discussed by Brothers (1997), Seligman's model therefore depended on identifying a particular class of animal behaviours as equivalent to an apparently discrete emotional state in humans. Faced by the observation that depressed patients often claim excessive responsibility for the misfortunes in life, the theory was then modified to include an attributional component. According to the revised learned helplessness theory of Abramson *et al.* (1978), depression therefore occurs when the individual experiences negative events as uncontrollable but also attributes them to causes which are internal to the self, stable over time, and global in their impact of areas of the individual's life. Subsequent research indicated that depressed patients, on the whole, did make the expected attributions for negative events, but much less clearly indicated that attributions (especially of internality) were trait vulnerability markers for depression as the theory supposed.

In the wake of these inconsistent findings, Abramson *et al.* (1989) further revised the theory, and argued that attributions were distal causes of hopelessness, which was now considered the proximal mediator of depressed mood. They suggested further that the model was only valid for a subtype of depression, which was labelled 'negative cognition' depression. In order to avoid the otherwise inevitable circularity of this position, Rose *et al.* (1994) compared depressed patients with a pessimistic cognitive style with those who appeared to lack this style, finding that the former group were more likely to have a diagnosis of personality disorder, and were more likely to have experienced difficult or abusive relationships with their parents. These

findings imply clearly that attributions play an important role in psychopathology, but do not provide a particularly compelling case for allocating them a specific causal role in a subtype of depression. To complicate matters further, other researchers have shown that the so-called 'depressogenic' attributional style is also observed in people diagnosed as suffering from anxiety disorders (Mineka *et al.*, 1995).

These disputes can be resolved by abandoning the idea that attributions are linked to a discrete and readily identifiable condition of depression. For example, Tennen & Herzenberger (1987) showed that attributional style was predictive of self-esteem, and that the apparent relationship between attributions and depression disappeared when self-esteem was included as a covariate. This observation raises the possibility that other behaviours and experiences which are sometimes subsumed under the label of depression may be accounted for by other mechanisms. For example, some authors have argued that disruption of circadian rhythms is the core feature of depression (Healy, 1987), but this would seem to be a better explanation of those symptoms which are sometimes described as 'biological' (early wakening, fatigue and loss of appetite) rather than problems of self-esteem that appear to be associated with abnormal attributions. The tangles which cognitivists have got themselves into, shown in this short section, have been a function of them accepting the concept of depression uncritically. Like other functional psychiatric diagnoses it is a professional reification about human misery, not a fact. If the concept is not working as a coherent pre-empirical notion perhaps we should review its utility instead of generating more and more empirical studies producing more and more ambiguous findings about 'depression'.

Implications for mental health research and practice

We have argued that the contemporary western medical notion of 'depression' is confused, woolly and inadequate as a basis for formulating mental health problems. We have also argued that two major epistemological positions about psychological distress (medical naturalism and social constructionism) do not provide adequate practical solutions to the problems created by this conceptual incoherence. We have suggested that a third or middle position of critical realism is a more helpful approach to mental health problems, as it ensures a proper caution about historical and cultural relativism, without degenerating into the unending relativism and nihilism attending social constructionism (Bhaskar, 1990, Greenwood, 1994; Pilgrim & Rogers, 1994; Busfield, 1996). This position respects empirical findings about the reality of misery and its multiple determinants but does not collapse into the naïve realism of medical naturalism. It accepts causal arguments but remains sensitive to the relationship between empirical methods and pre-empirical (e.g. professional) interests and social forces.

One implication of our analysis concerns research. Given that the concept of depression is insufficiently narrow to allow the specification of cognitive and biological mediators of distress, it may be necessary to focus research on more narrowly defined behaviours and experience, for example low self-esteem, fatigue and anhedonia, experienced in specific social contexts. However, we have also argued that the concept of depression is insufficiently broad to allow a full exploration of the social and political conditions which contribute to human misery, and that the current focus on a psychiatric diagnosis may mystify and obscure these

conditions. For these purposes, therefore, a much broader concept of human misery may be required as well, allowing sociological or social-psychological studies which focus on the supra-individual phenomena associated with family, social and work life.

A second implication of a critical realist view of misery concerns problem formulation and intervention. The current outcome literature on the treatment of 'depression' suggests that many therapeutic approaches are helpful, but that a combination of antidepressant medication and cognitive–behaviour therapy is the most efficient treatment option (e.g. Klerman *et al.*, 1994). This conclusion, if valid (and Fisher & Greenberg (1997) dispute the findings about the efficacy of anti-depressants), may be explicable in terms of a 'blunderbuss' approach. Antidepressants have a fairly non-specific effect on negative mood as well has having anxiolytic effects (Goldberg & Huxley, 1992). At the same time, the positive connotations about reality encouraged by cognitive–behaviour therapy serve to reverse demoralisation and demotivation. While it is not surprising, then, that a biological and cognitive pincer approach seems to be effective, compared to no treatment, when helping miserable people, the danger of these reductionist approaches to treatment is that they may mystify the oppressive social conditions which generate the distress experienced by the patient – the technical fix of treatment may obscure our pathways into misery. For example, insecure work and poor task control increase the risk of psychological distress in workers (Marmot *et al.*, 1991) and unemployment raises the probability of both demoralisation and suicide (Fryer, 1995). The point diagnosis (or 'identification') of 'depression' in individual patients will never reveal these relationships, which require social not psychiatric methods of inquiry.

Instead of focusing on the end-point diagnosis of 'depression', therapists might seek idiosyncratic formulations of the antecedent and current conditions (including the patients's individual attributed meanings) which have shaped the patient's expression of this misery. Signs of this approach are already evident within therapeutically orientated froms of community psychology (e.g. Holland, 1979) and in feminist therapy (e.g. Eichenbaum & Orbach, 1982). However, because of the latter's psychodynamic roots, it has been criticised for still being prone to psychological reductionism (Busfield, 1996; Pilgrim, 1997). A more holistic understanding would attend to the social determinants of misery *and* would involve exploring the patient's individually attributed meanings. This would be similar to the current practice of cognitive–behaviour therapy (CBT), but would also involve applying the lessons learned from the work of Brown and his colleagues, together with other evidence about antecedent stressors explored in other sociological research on health and quality of life. In its traditional form CBT is also prone to psychological reductionism, as it singularly focuses on the patient' cognitive processes, implying that reality is not a problem, only the way we construe it. (Logically these are not mutually exclusive – we do not have to only problemetise one or the other, both/and are possible.)

In order to avoid the pitfall of victim blaming in the psychodynamic and cognitive treatments of 'depression', attributed meanings and external reality need to be attended to in equal part. This would require a therapeutic flexibility which responds to the experienced distress of different individuals from different circumstances. It would not target casualties at the expense of exploring the sources of distress, and it would not take for granted the validity of the shifting diagnostic con-

cepts of contemporary psychiatry, such as 'depression', which have been shaped by particular social and cultural contexts and become dubious reifications.

References

Abramson, L.Y., Metalsky, G.I. & Alloy, L.B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review,* **96**, 358–372.

Abramson, L.Y., Seligman, M.E.P., & Teasdale, J.D. (1978). Learned helplessness in humans: critique and reformulation. *Journal of Abnormal Psychology,* **78**, 40–74.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual for Mental Disorders, 4th edition.* Washington, DC: APA.

Bannister, D. (1968). The logical requirements of research into schizophrenia. *British Journal of Psychiatry*, **114**, 181–188.

Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive Therapy of Depression.* New York: Guilford Press.

Becker, J. (1977) *Affective Disorders.* New Jersey: General Learning Press.

Bentall, R.P., Jackson, H. F. & Pilgrim, D. (1988). Abandoning the concept of schizophrenia: some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology*, **27**, 303–324.

Berrios, G.E. (1995). Mood disorders. In G. Berrios & R. Porter (Eds.), *A History of Clinical Psychiatry.* London: Athlone Press.

Bhaskar, R. (1990) *Reclaiming reality* London: Verso.

Boyle, M. (1990). *Schizophrenia: A scientific delusion?* London: Routledge.

Brothers, L. (1997). *Friday's Footprint: How society shapes the human mind*. Oxford: Oxford University Press.

Brown, G.W. & Harris, T. (1978). *Social Origins of Depression.* New York: Free Press.

Brown, G.W., Harris, T.O. & Hepworth, C. (1995). Loss, humiliation and entrapment among women developing depression: A patient and non-patient comparison. *Psychological Medicine,* **25**, 7–21.

Browne, A. & Finklehor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin*, **99**, 66–77.

Bury, M. (1986). Social constructionism and the development of medical sociology. *Sociology of Health and Illness,* **8**, 137–169.

Busfield, J. (1996). *Men, Women and Madness.* London: Routledge.

Chan, D.W. (1990). The meaning of depression: Chinese word associations. *Psychologia*, **33**, 191–196.

Clark, L.A. & Watson, D. (1991). Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, **100**, 316–336.

Davison, G.C. & Neale, J.M. (1990). *Abnormal Psychology.* New York, Wiley.

de Swaan, A. (1990). *The Management of Normality*. London: Routledge.

Eichenbaum, L. & Orbach, S. (1982) *Outside In, Inside Out.* Harmondsworth: Penguin.

Eysenck, H.J. (1977). *Biological Basis of Personality*. Springfield: CC Thomas.

Fenton, S. & Sadiq, A. (1991). *Asian Women and Depression.* London: Commission for Racial Equality.

Fisher, S. & Greenberg, R. (1997). *From Placebo to Panacea.* New York: Wiley

Fryer, D. (1995). Labour market disadvantage, deprivation and mental health (1994 CS Myers lecture). *The Psychologist*, **8**, 266–272.

Goldberg, D. & Huxley, P. (1992). *Common Mental Disorders: A bio-social model*. London: Routledge.

Golden, R.N. & Janowsky, D.S. (1990). Biological theories of depression. In B.B.Wolman & G. Stricker (Eds.), *Depressive Disorders*. New York: Wiley.

Goodwin, F.K. & Jamison, K.R. (1990). *Manic-depressive illness.* Oxford: Oxford University Press.

Greenwood, J.D. (1994). *Realism, Identity and Emotion.* London: Sage.

Healy, D. (1987). Rhythm and blues: neurochemical, neuropharmacological and neuropsychological implications of a hypothesis of circadian rhythm dysfunction in the affective disorders. *Psychopharmacology,* **93**, 271–285.

Healy, D. (1997). *The Anti-depressant Era.* Harvard: Harvard University Pres.

Hoff, P. (1995). Kraepelin. In G. Berrios & R. Porter (Eds.), *A History of Clinical Psychiatry.* London: Athlone Press.

Holland, S. (1979). The development of an action and counselling service in a deprived urban area. In M. Meacher (Ed.) *New Methods of Mental Health Care.* London: Pergamon.

Howell, S. (1981). Rules not words. In P. Heelas & A. Lock (Eds.), *Indigenous Psychologies: The anthropology of the self.* San Diego: Academic Press.

Ingleby, D. (1981) (Ed.). *Critical Psychiatry*. Harmondsworth: Penguin.

Joint Royal Colleges Report (1996). *Chronic Fatigue Syndrome.* London: Royal College of Physicians, Royal College of Psychiatrists and Royal College of General Practitioners.

Kasanin, J. (1933). The acute schizoaffective psychoses. *American Journal of Psychiatry,* **90**, 97–126.

Kendell, R.E. (1975). *The Role of Diagnosis in Psychiatry.* Oxford: Blackwell.

Klerman, G.L., Weissman, M.M., Markowitz, J., Glick, I., Wilner, P.J., Mason, B. & Shear, M.K. (1994). Medication and psychotherapy. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of Psychotherapy and Behavior Change*. New York: Wiley.

Klienman, A. (1988). *Rethinking Psychiatry.* New York: Free Press.

Leff, J. (1973). Culture and the differentiation of emotional states. *British Journal of Psychiatry,* **123**, 299–306.

Levy, R.I. (1984). The emotions in comparative perspective. In K.R. Scherer & P. Ekman (Eds.), *Approaches to Emotion.* New Jersey: Erlbaum.

Lewis, A. (1934). Melancholia: A clinical survey of depressive states. *Journal of Mental Science*, **80**, 277–278.

Lutz, C. (1980). *Emotion words and emotional development.* Unpublished doctoral thesis, University of Harvard.

MacDonald, D. (1981). *Mystical Bedlam*. Cambridge: Cambridge University Press.

Marmot, M.G., Davey Smith, G. Stansfield, S., Patel, C., North, F. & Head, J. (1991). Health inequalities amongst British civil servants: The Whitehall II study. *Lancet*, **337**, 1387–1393.

Marsella, A. (1981). Depressive experience and disorder across cultures. In H. Triadis & J. Draguns (Eds.), *Handbook of Cross Cultural Psychology*. Boston: Allyn and Bacon.

Matsuyama, Y., Hama, H., Kawamura, Y. & Mine, H. (1978). An analysis of emotional words. *Japanese Journal of Psychology,* **49**, 229–232.

McEvedy, C. P., & Beard, A. W. (1970). The concept of benign myalgic encephalomyelitis. *British Medical Journal,* **1**, 20-35.

Mendels, J. (1970). *Concepts of Depression.* New York: Wiley.

Mineka, S., Pury, C.L. & Luten, A.G. (1995). Explanatory style in anxiety and depression. In G. M. Buchanan & M.E.P. Seligman (Eds.), *Explanatory Styles*. Hove: Erlbaum.

Montgomery, S. (1990). *Anxiety and Depression.* London: Livingstone.

Murphy, E. (1982). Social origins of depression in old age. *British Journal of Psychiatry* , **142**, 135–142.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London: Sage.

Pilgrim, D. & Rogers, A. (1993). *A Sociology of Mental Health and Illness.* Milton Keynes: Open University Press.

Pilgrim, D. & Rogers, A. (1994). Something old, something new...: Sociology and the organisation of psychiatry. *Sociology,* **28**, 521–538.

Pilgrim, D. & Treacher, A. (1992). *Clinical Psychology Observed*. London: Routledge.

Pilgrim, D. (1997). *Psychotherapy and Society*. London: Sage

Power, M. & Dalgleish, T. (1996). *Cognition and Emotion: From order to disorder.* London: Psychology Press.

Ramsay, M. A. (1986). *Post-viral Fatigue Syndrome: The saga of Royal Free disease.* London: Gower.

Rogers, A. & Pilgrim, D. (1997). The contribution of lay knowledge to the understanding and promotion of mental health. *Journal of Mental Health* , **6**, 23–35.

Rose, D. T., Abramson, L. Y., Hodulik, C. J., Halberstadt, L. & Leff, G. (1994). Heterogeneity of cognitive style among depressed inpatients. *Journal of Abnormal Psychology,* **103**, 419–429.

Russell, J.A. (1980). A circumplex model of affect. *Journal of Personality and Social Psychology,* **45**, 848–856.

Russell, J.A. (1991). Culture and categorization of emotions. *Psychological Bulletin,* **110**, 426–450.

Seligman, M.E.P. (1975). *Helplessness: On depression, development and death.* San Francisco: Freeman.

Stone, M. (1985). Shellshock and the psychologists. In W.F. Bynum, R. Porter & M. Shepherd (Eds.), *The Anatomy of Madness, Vol. 2*. London: Tavistock.

Szasz, T.S. (1961). *The Myth of Mental Illness: Foundations of a theory of personal conduct*. New York: Harper Row.

Tennen, H. & Herzenberger, S. (1987). Depression, self-esteem and the absence of self-protective attributional biases. *Journal of Personality and Social Psychology*, **52**, 72–80.

Tyrer, P. (1990). The division of neurosis: A failed classification. *Journal of the Royal Society of Medicine,* **83**, 614–616.

Wallace, A.F.C. & Carson, M.T. (1973). Sharing and diversity in emotional terminology. *Ethos,* **1**, 1–29.

Willner, P. (1985). *Depression: A psychobiological synthesis.* New York: Wiley.

World Health Organisation (1992). *ICD-10: International statistical classification of diseases and related health problems* (10th revision edn.) Geneva: World Health Organisation.