

Town&Country

The Elusive Affliction

Today, Tracy Thompson is both the mother of a three-year-old and an award-winning journalist with *The Washington Post*. For nearly thirty years, she has struggled with depression. And she is not alone in that dark territory. More than 19 million Americans -- almost twice as many women as men -- are afflicted with clinical depression. Some of them will die by their own hand. Depression costs more than \$40 billion a year in lost wages and health-related expenses. The World Health Organization estimates that by the year 2020, depression will be second only to heart disease as the world's leading cause of death and disability.

And it is on the rise; experts have seen a marked increase since World War II. Some of the change is probably due to greater awareness and better diagnosis. But also, says Myrna M. Weissman, M.D., professor of psychiatry and epidemiology at Columbia University's College of Physicians and Surgeons in New York and author of the new book *Comprehensive Guide to Interpersonal Psychotherapy*, "The situations we know to elevate the risk of depression in vulnerable individuals are increasing. There are more divorces, people are moving around more, living alone; there's more stress."

Fortunately, the stigma of depression has lifted measurably in recent years. As Tracy Thompson says, "I went from believing that the *Post* would let me go if anyone discovered my secret to knowing I could write a book about it without jeopardizing my future." Her journey has taken her through an extraordinary period of change in how mental health is viewed, diagnosed and treated in the U.S. Because more is known about the brain and genetics and how the two interact with the environment to affect emotional well-being, new, more targeted treatments have been developed. Perhaps because of this progress in medical understanding, the subject of depression is less taboo. It may also be because people with these illnesses are coming out of the shadows. High-profile sufferers -- among them Pulitzer Prize-winning writer William Styron, *60 Minutes* correspondent Mike Wallace, Tipper Gore, television journalist Deborah Norville, and actors Rod Steiger and Winona Ryder -- have spoken publicly about their battles with the demons.

Causes of Depression

But that is not to say the public discourse concerning depression can ever be straightforward or clear. The topic is exceedingly complex and controversial, its concepts elusive. These days, the biochemical explanation of depression is widely and enthusiastically embraced. The solution, according to this view, lies primarily in a regimen of pills. But are our moods, emotions and thoughts really nothing more than the effects of chemicals mixing it up in our bodies? Even if they are, is medication the best or only way to tame those moods and emotions? Do we want to tame them? And given the fact that suicide is a very real and final "symptom" of depression, is it right to question the use of antidepressants?

Viewed through another lens, depression may be seen not so much as a chemical imbalance but as a complicated mystery woven of many influences in our lives, from the spiritual to the mundane. Is it our responsibility to unravel the mystery? Is it reasonable to think we can take control of our moods by shaping our lives differently?

Charting a New Course "We've begun to create new models for how we think about mental health," says Dr. Weissman. "By acknowledging that the mind can affect the body and that the environment, which we can influence, is acutely involved in physiological function, we've expanded the possibilities for treating -- and preventing -- many disorders." The new models assert that an event in one's life could cause changes in the structure of the brain, just as changes in the brain can cause disruptions in one's life. And they recognize that the symptoms of depression most likely spring from several sources.

This important shift in thinking has expanded the debate about depression. What was once, as Styron puts it in his book *Darkness Visible*, a "schism between the believers in psychotherapy and the adherents of pharmacology" has evolved into a multisided conversation about layers of causation and many facets of treatment, including medication and psychotherapy, as well as diet, exercise, spirituality, stress control and other lifestyle modifications.

Treatment Choices

Although Prozac and its fellow antidepressants have been catapulted to prominence in the treatment arena, there's growing interest among scientists in how events in the world -- one's lifestyle and experience -- might trigger the malady, and how a wider understanding of these factors might provide improved strategies for dealing with depression. "We accept these relationships between lifestyle and health when we think about hypertension," says Frederick K. Goodwin, M.D., director of the Center for Neuroscience, Medical Progress and Society at George Washington University Medical Center and past director of the National Institute of Mental Health. "Severe hypertension needs medication; milder forms can be handled by diet, exercise and stress reduction. Why not depression?"

Depression may be nature's way of letting us know that something's gone awry in our lives and that it's time for a change, according to Randolph M. Nesse, M.D., director of the Evolution and Human Adaptation Program at the University of Michigan's Institute for Social Research. As a natural adaptation that makes you slow down and reflect, depression can be viewed as a mechanism that keeps you from persisting too long in a behavior or activity that has grown increasingly unproductive or unhealthy -- a bad marriage, perhaps, or an unfulfilling career, even poor nutrition or sleeping habits. "You can't really fix the depression until you learn new, healthier ways of dealing with the problems in your life," says Ralph Carl Mumpower, a psychologist in Asheville, North Carolina.

Depression's Grip

Depression is the most common of psychiatric illnesses, affecting about 10 percent of all Americans in a given year. Researchers don't know for sure why life events cause depression in some and not in others. It has been established that, for many sufferers, genetic predisposition plays a part. Interestingly, however, not all genetically predisposed individuals do get depressed.

"We confuse depression with the blues," says **Scott E. Ewing, M.D.**, director of the Depression and Anxiety Disorder Service at **McLean Hospital** in Belmont, Massachusetts. "We've all suffered from sadness and despair. We tend to think if we got better, the next person can too." The confusion persists in large part because of the very nature of the symptoms of depression. The patient must try to explain why he is unable to get out of bed, can't concentrate, is plagued by feelings of worthlessness. Blood tests and tissue cultures cannot reveal the source of pain. Paul Gottlieb, publisher and editor in chief of Harry N. Abrams, Inc., the prestigious art-book publishing company in New York, tells of gradually coming to realize that his "everyday feelings" were something more. "When my symptoms began I was just turning 40, and I thought, 'Ah, this is my midlife crisis,'" he says. "It kept getting worse. Night after night, I'd lie in bed, sleepless. When morning finally came, it would be a major effort to turn the covers back and get up. It's as if the walls were coming in at me. Instead of engaging with people or circumstances, I was drawn completely inward. I was terrified people would find out that I was a shell. I spent tremendous effort controlling my behavior, controlling my reactions. Toward the end, suicidal thoughts came daily. This went on for six years, until I was sure I would follow through with the suicide -- that's when I finally got the help I needed. Ten days after I started taking medication, I was better. It was miraculous. Since then I have not suffered what I consider the illness of depression."

How to Know

Anyone who experiences the sadness brought on by the death of a loved one, or the anxiety generated by a stressful job, might know depression, at least for a time. But what does it mean to be clinically depressed? Is the difference between simple sadness and deep depression one of degree? The distinction, medical experts say, lies in the duration and severity of the symptoms.

"If your blue mood doesn't interfere with your life, and if it lasts for only a couple of weeks, then you are sad, or mildly depressed," Dr. Scott Ewing explains. "If it devastates your life and goes on for weeks without abatement, you should seek treatment."

The official definition of the different kinds of depressive disorders can be found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), the bible of psychiatric diagnosis. The symptoms of major depression usually appear sporadically, in what are called depressive episodes; they affect all parts of the patient's life -- physical, emotional, mental -- and persist for weeks at a time. The illness ranges in form from relatively moderate to severe, the latter marked by complete mental incapacitation, including auditory and visual hallucinations and delusions. The symptoms of depression in its mildest form can lead to a diagnosis of dysthymia, a chronic condition in which the patient is always slightly depressed.

Several types of depression are associated with discrete events. Postpartum depression follows the birth of a child; Seasonal Affective Disorder (SAD) is related to the shorter daylight of winter; and premenstrual depression affects women just prior to and during their periods. "We don't know what the mechanism is that underlies these episodes," says Michael Cochran, M.D., a psychiatrist on the clinical faculty at Stanford University Hospital, "but they are very real. The symptoms are the same as any case of major depression."

The Road to Wellness

Current research indicates that more than 80 percent of depressed patients will respond to treatment, yet the National Institute of Mental Health says that nearly two thirds won't get help. Why? The lethargy that is a symptom of depression can keep people from seeking help; so can the social stigma or even a lack of understanding of the disease. And since severe depression is an episodic illness, the sufferer often just waits it out. Finally, with the recent changes in the healthcare system, more and more mental illnesses are first diagnosed and treated by primary-care physicians rather than by psychiatrists or psychologists. Although primary-care physicians are becoming more sensitive to emotional disorders, there is a chance of misdiagnosis.

Once the depressed patient gets over the hurdle of diagnosis, he faces some twists and turns on the road to recovery. With his doctor (primary-care or psychiatrist), he will work out a therapy plan, probably starting with medication and psychotherapy. Some patients experiencing mild depression may try St. John's wort or other alternative remedies. A small percentage may ultimately elect to have electroconvulsive therapy (ECT), a treatment with a controversial reputation but an 80 percent success rate, especially in cases where psychotherapy or medications haven't worked.

Many doctors also recommend paying attention to lifestyle triggers: "Depressives tend to be especially sensitive to disruptions in the circadian clock," reports Dr. Frederick Goodwin. "So I tell them they need to respect their sleep-wakefulness cycle. And exercise is important in two respects: one, for its metabolic effect on the brain, and two, because it regulates the body clock. You should exercise at the same time every day. Diet should be geared to minimizing blood-sugar variations -- they're not good for brain function and can mimic symptoms of depression. Alcohol affects the same neurotransmitters that are involved in depression."

Therapy vs. Medication

"The most dramatic shift in the treatment of depression over the last ten years has been the rebirth of psychotherapy," says Dr. Goodwin. "New studies using methods of psychopharmacology and focusing on therapies that take shorter periods of time than the old analytic model have shown synergistic effects between psychotherapy and medications." The debate about pills versus talk today is irrelevant. "I would say do it all," says Nada Stotland, M.D., M.P.H., chairman of the psychiatry department at Illinois Masonic Medical Center in Chicago. "Depression can be a life-threatening condition, and in reasonable hands neither the new medications nor talk therapy will do harm. Maybe you'll never know which helped you, but if you end up feeling better, who cares?"

Dr. Cochran points to recent data showing that talk therapy by itself works for mild to moderate depression, but that with moderately severe to severe depression, talk alone is not as effective as

drug therapy coupled with some form of psychotherapy. "I had a patient who said she'd been depressed for about three months," Dr. Cochran explains. "Her concentration was lousy and her self-esteem was low. Her energy level was okay, her appetite was fine, her sleep was normal and she wasn't suicidal. She was having no trouble with her day-to-day activities, taking care of her husband and her kids. Since she had only the two symptoms, she didn't meet the criteria of five symptoms required for a diagnosis of clinical depression, and since she had begun feeling bad only three months before, it wasn't dysthymia. So I decided against medication. I learned that she had recently given up a high-powered job to move to California with her family. She was feeling conflicted about her new role of being just a mom to her young kids, about giving up the status of her old job. Once we looked at the issue and she sorted out what was important to her, the symptoms went away."

If, however, the downward-spiraling mood takes on a life of its own, separate from the triggering event, and the patient begins to dwell on the emptiness provoked by it, the endless accumulation of losses in her life, the guilt and shame of not being able to control her emotional deterioration, she may be confronting major depression. She can be taught to redirect her negative thoughts (that is psychotherapy's role), but only after the downward cycle has been stabilized enough that she can focus on the therapy -- that's medication's role.

Antidepressants: The Pros and Cons

From the moment Prozac was introduced in 1987 as a "miracle cure," it has been buffeted by controversy. It was the first of a class of antidepressants known as selective serotonin re-uptake inhibitors, or SSRIs, which quickly became the most common treatment for depression. Seventy percent of patients got relief with the first drug they were prescribed.

SSRIs (among them Prozac, Paxil and Zoloft) work by targeting serotonin, one of the chemicals that help the neurons involved in the mood-regulating system of the brain to communicate with each other. The impact that these medications have on people's moods, the way they perceive things, and their ability to enjoy life has led researchers to believe that thoughts, perceptions and feelings are rooted to a surprising degree in the brain's biochemistry.

Serotonin, most researchers believe, is particularly important in regulating mood, and depressives appear to have too little of it. By making more available, SSRIs relieve the patient's symptoms. Still, serotonin affects more than mood -- it influences everything from sexual behavior to digestion. Researchers have begun sorting out the many different receptors that are involved in serotonin's various functions, and in an effort to reduce side effects, they are homing in ever more tightly on those receptors that affect only mood. SSRIs are a major improvement over previous antidepressants -- the tricyclics and monoamine oxidase inhibitors (MAOIs). The older drugs aren't as targeted, altering the levels of many different brain chemicals, including dopamine and norepinephrine. As a result, these drugs, though equally effective as SSRIs, influence a wider range of brain functions and spawn a wider range of side effects. More important, both can be deadly if the patient overdoses. SSRIs are unlikely to be deadly even with an overdose.

But the new wave of antidepressants have fallen far short of ending depression in our time. As many as 30 percent of patients respond to the medications only partially or not at all. Some find that the drugs' effectiveness begins to wane over time; still more can't bear the side effects: SSRIs can cause jitteriness, sexual dysfunction, headaches, sleep problems and weight changes. They can be dangerous when taken in combination with MAOIs. (One of the newest drugs on the market, Celexa, eliminates some of the side effects by being even more selective in targeting serotonin receptors.)

Managing Depression

Many of the questions generated by the stupendous growth in antidepressant use remain unanswered. Is it too easy to dispense pills whenever a patient complains of being a bit depressed? Is it possible that a quick fix of medication relieves the symptoms but masks the "real" problems, leaving them bottled up and dangerously unresolved? "At some point the patient must take personal responsibility for his own well-being, or the relief will be temporary," offers Ralph Carl Mumpower.

As Tracy Thompson tells it, "A turning point came in February 1990. I'd tried everything I knew to endure this life and I just couldn't do it anymore. Luckily, I had enough sense to call an old boyfriend and say "I'm in serious trouble." He came right away and took me to a hospital. "The doctors took one look at me and told me I was severely depressed. Suddenly it hit me. I'd been fighting this illness for all those years, and I really didn't know. Then I started reading, educating myself about it. I realized I wasn't bad or defective. I was sick and I could get better. Most of the time, I can manage this illness."