Case histories

Depression

Meteorology, economics, and geology—all have their depressions. Mid-19th century laboratory physiologists also spoke of depression—a decline in the biochemical output of an organ—and this usage, with its connotations of functional materialism, haunts the contemporary concept of depression. As the physician and historian Laura D Hirshbein argues, depression is "a twentieth-century phenomenon that incorporates assumptions about gender, profession, and science", reflecting the shifting balance of power between theories, therapies, and patients' experiences.

In the last few centuries, western concepts, language, and behaviours of feeling have been transformed. Older categories like "appetite" and "passion" drew on Christian notions of personhood, but emotion, a term that emerged from 19th-century psychology, was, in the words of the historian Åsa Jansson, "at once physiological and psychological—and not necessarily subject to volition". Early modern melancholy, sometimes taken as a synonym for depression, was strikingly different, a condition of fantasies, fixation, and suspicion. The preoccupations of 19th-century industrial societies were reflected in new visions of physical and mental breakdown. An insufficient supply or an excessive depletion of energy might lead to neurasthenia and degeneration, just as inadequate or needless spending might provoke an economic depression. In Germany the psychiatrist Wilhelm Griesinger borrowed early neurological work on reflex action to reconceive melancholy as neurophysiology, a form of overstimulation generating "morbid feelings".

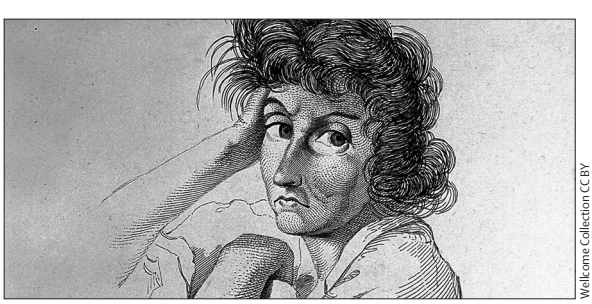
Influential practitioners in the UK and Germany took up Griesinger's ideas, partly as a way of explaining the origins of affective disorders without appealing to undetectable brain lesions. At the start of the 20th century psychiatrists and neurologists regarded depression as a symptom, one aspect of broader diagnostic categories like manic-depressive psychosis or neurosis. In 1922, the Boston neurologist and psychiatrist Abraham Myerson proposed "anhedonia" as a "depressive symptom-complex", particularly common, he thought, among women. From 1935, Myerson treated his anhedonic patients with amphetamines, reasoning that the drugs would recalibrate the balance between the restful and wakeful centres of the brain. This approach helped, in the words of the historian Nicolas Rasmussen, to establish "a society of psychiatric outpatients routinely consuming mood-altering drugs en masse".

Myerson's work foreshadowed the emergence of depression as a distinct condition in the 1950s and 1960s, within the networks of the medical–industrial complex. Clinicians working closely with pharmaceutical companies, and deploying new kinds of statistical trials, initially took a scattergun approach to finding new drugs. Imipramine, the first tricyclic antidepressant, had been synthesised as an antihistamine, and iproniazid, the first monoamine oxidase inhibitor, was initially used to treat tuberculosis. New theories and diagnostic frameworks were bootstrapped out of these empirical studies: as Hirshbein put it, "medications that seemed to work on patients who appeared to be depressed were labelled 'antidepressants', while patients who responded to antidepressants were in turn diagnosed with depression". Animal models suggested that antidepressants all worked on serotonin and norepinephrine neurochemistry, while British psychiatrists emphasised the distinction between exogenous depression, evidently related to difficulties in life, and endogenous depression, with no obvious provoking factor.

In the 1970s and 1980s, this consensus remained controversial. Was depression a characteristically female disease, linked in some way to the hormonal cycle of ovulation? And just how prevalent was it? Neo-Kraepelinian diagnostic checklists were repurposed as screening tools, highlighting the large numbers of people who reported symptoms. This neuropharmacological framing of depression came of age in 1980, when it appeared as a distinct disease in *DSM-III*.

Since then, clinical and cultural attitudes to depression have shifted again, partly in response to the selective serotonin reuptake inhibitors—the first rationally designed psychotropics and one of the most widely prescribed classes of drugs. Fluoxetine (Prozac), in particular, has provoked eulogies and denunciations, while some studies suggest that new serotonin-norepinephrine reuptake inhibitors are more effective. Psychological therapies like cognitive behavioural therapy, developed in the 1980s and 1990s, are also effective and used alone or with pharmacotherapy, while increasingly popular mindfulness techniques can give patients a sense of agency over negative thoughts and feelings. In the past decade, more attention has been paid to depression as a threat to global health, particularly in low-income nations, but WHO projections suggest that by 2030 it will be the most common disabling condition in the world.

Richard Barnett
richard@richardbarnettwriter.com



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For more on **depression** see https://www.thelancet.com/clinical/diseases/depression

Further reading

Healy D. The antidepressant era, Cambridge, MA: Harvard University Press, 1997

Hirshbein LD. Science, gender and the emergence of depression in American psychiatry, 1952–1980. *J Hist Med Allied Sci* 2006; **61:** 187–216

Rasmussen N. Making the first anti-depressant: amphetamine in American medicine, 1929–1950. *J Hist Med Allied Sci* 2006; **61:** 288–323