First Impressions

In symbolic terms, diagnosis represents the naming of a set of experiences; a formal move from health to illness; grappling with and negotiating the sick role; and usually the first step into the medical world of doctors and treatments.\(^1\) Diagnosis impacts on how individuals view themselves, but individuals also apply their own meaning and interpretation to their diagnosis.\(^2\) If an individual’s interpretation of her diagnosis throws her responsibility for certain thoughts, emotions and behaviours into doubt, then the place of those thoughts, emotions and behaviours as part of the self also comes under question.

In contrast with the variety and complexity of views of depression presented in the previous chapter, when I asked my interviewees how they initially reacted to their diagnosis, it became apparent that whether they were relieved or resigned, accepting, rejecting or nonchalant, their reaction was premised on a biomedical view of depression. It should be noted, however, that this medicalised view does not occur all the time and across the board. An individual’s account of her view of depression at the point of diagnosis can be in stark contrast with her view of depression at the time of interview.

Views of depression not only vary at different points in time within the individual but also among different groups of people. For instance, those who have not been diagnosed with depression tend to place more weight on non-medical explanations of the cause of depression than do those who have been diagnosed (Kuyken et al., 1992; Ogden et al., 1999; Thwaites et al., 2004; Tully et al., 2006). Nevertheless, this is not to say that lay views of depression in the West are decidedly non-medical. Jorm and colleagues (2000) found that people in Western cultures are more comfortable with professional models of depression and medical treatment than those in Eastern cultures – a finding which is perhaps not surprising given the prevalence of medical discourse in Western culture (Shaw, 2002).

Not only do people who have not been diagnosed with depression tend to view it in more demedicalised terms than their diagnosed
counterparts, but even physicians find it difficult at times to maintain a medicalised view of depression over a demedicalised view. In their study of 20 general practitioners (GPs) in the United Kingdom, Susan McPherson and David Armstrong (2009) found that when speaking about patients for whom antidepressants were ineffective, GPs tend to demedicalise depression. That is, GPs seem to attribute the ineffectiveness of medication in such patients either to the likelihood that the patient instead suffers from a personality problem (either a personality disorder, or is simply a difficult patient), which detaches the label “depression” from the patient, or to the view that antidepressants are no better than placebos anyhow, which demedicalises the treatment. GPs are also more likely to demedicalise depression in underprivileged areas (Chew-Graham et al., 2000) and in the elderly (Burroughs et al., 2006), tending to perceive it as a normal reaction to stressful circumstances. The result is that patients can not only be medicalised but also demedicalised (McPherson & Armstrong, 2009). This demedicalisation of depression among physicians can extend to causal explanations. For instance, Roanne Thomas-MacLean and Janet Stoppard’s (2004) interviews with 20 primary care physicians in Canada found that their medicalised views of depression conflicted with their recognition of the role played by the individual’s life context. Physicians spoke of depression as both “normal” and “wrong.” However, if something is “wrong” with the patient, it should not simply be a normal reaction to stressful circumstances. If it is a normal or understandable reaction to stressful circumstances, it is the situation or the environment that is “wrong”. Depression, of course, need not be viewed in this either/or dichotomy. The plasticity of the brain means that trauma and stress, by impacting on one’s psychology, can alter the brain’s neural circuitry. Yet a strict biomedical model states that changes to neural circuitry or brain chemistry precede the psychological state. Whether or not this causal model fits with their experiences of depression, the women I spoke with felt that what it gave with one hand, it took with the other.

The Biomedical Model: A Double-Edged Sword

The biomedical model underlay almost all interviewees’ initial reactions to their diagnosis, either as an explanation for their feelings of relief or doubt, their fears about stigma or their feelings of being labelled. Debbie, for example, felt that her diagnosis (bipolar depression) was bound up with the biomedical paradigm:
So then how did you feel when they first gave you the diagnosis?

I felt kind of invaded, because they’d attached something to me which seemed very clinical and scientific.

Gail, the only interviewee who did not have a biomedical view of the diagnosis, had gone directly to a psychotherapist for treatment with Chinese herbs because she did not subscribe to the biomedical narrative of depression and her memory of her mother’s treatment for schizophrenia made her determined to avoid Western medical treatment. Gail’s relief upon being diagnosed was instead predicated on her feeling that “I felt I knew I was facing a problem and the problem had a clear name. And because the problem had a clear name, there must be a clear solution to it.”

The biomedical model of depression clears the individual of responsibility for her condition but also has the potential to condemn her to something chronic, for according to the model there is no cure – no “exit” from the depression career – only ways of managing it. This is seen as being especially true of bipolar depression, with numerous websites and articles reinforcing the message that bipolar depression is a serious, chronic and incurable illness (e.g. Arehart-Treichel, 2002; Everyday Health, 2010; Keitner et al., 2009; Melbourne MediBrain Centre, 2009; Torpy, 2009). Layla clearly articulated the sentiment that many others voiced concerning the prevailing opinion that bipolar depression is more serious than unipolar depression:

It sounds really silly, but I feel like if you say to someone “Oh I’ve got bipolar”, then they take it slightly more seriously. But if you say “I’ve got depression”, then they think “Oh, you’re really sad”. [laughs] “Poor you”, or “You’ve got PMT” or something. Whereas if you say you’ve got bipolar, I think people take it a bit more, “Oh that’s an illness. Oh that’s a disease.”

Those who initially felt relief upon being given a diagnosis (such as those who felt it meant depression was not their fault, that they were not going insane) and those who felt that they didn’t know themselves anymore were reacting to the former aspect of the biomedical model which they seemed to associate with the diagnosis – that is, responsibility for their condition and associated behaviour lies with their chemicals, not with society or their selves. Miriam illustrates this view:

So how did you feel when [the doctor] made that diagnosis?

Relieved. Because I had wondered if I was going insane. Because it’s not normal to get upset because you’ve forgotten to put the water in the fridge or something like that. And I was aware – very aware – that it wasn’t normal. And I wanted it to be
something chemical that could be fixed. Or that could not possibly be construed as my fault. So the diagnosis of depression was a relief.

That such relief is predicated on a biomedical understanding of depression carries with it risks that have been identified by several scholars thus far. Fredrik Svenaeus uses the phenomenological notion of “bodily resonance” (in depression, a sense that one is out of tune with the world) as an explanation for serotonin’s relevance to feelings and the wider context in which the body is situated and cautions against an over-reliance on the biomedical model:

... we enrich our biological accounts by providing them with this phenomenological dimension, by relating them to patterns of meaning constitution; otherwise, we risk mystifying biology – risk transforming it into something foreign to problems of everyday life. Discussing serotonin deludes us into blaming our brains, rather than ourselves and the societies we live in (Valenstein, 1998). (Svenaeus, 2007: 162)

Nikolas Rose (2007) argues that subjectivity has increasingly become understood in biological terms, thanks to the biomedical model – an argument that builds on Foucault’s (1998) notion of biopower as a way of managing groups through the use of technology. In this case, it is people’s emotions that are being managed through the use of medication. As Simone Fullagar elaborates:

[The neurochemically deficient self is one such figure who is required to exercise responsibility and self-control to restore and maximize their life potential via biomedical expertise [...] we can see the seductive power of biomedical explanations that reconfigure the problem of unsuccessful womanhood as a neurochemical problem that can be expertly and rationally managed. (Fullagar, 2009: 403–404)]

By negating any role that problematic social norms and cultural practices can play in causing depression, the biomedical model also plays into the patriarchal interest in turning attention away from sexist norms and practices that disproportionately affect women. Simone Fullagar, Michelle Lafrance and Janet Stoppard have all emphasised the gendered power relations within the societal problems that the biomedical model ignores. Many have also criticised the biomedical model for reducing the individual’s experience to a set of physical causes and symptoms (e.g. Aronowitz, 1998; Eisenberg, 1977; Lafrance & Stoppard, 2007; Scheper-Hughes, 1990; Taussig, 1980) as well as being individualistic and gender-blind (Nicolson, 1998; Pilgrim & Bentall, 1999; Stoppard, 2000). The biomedical model thus performs several duties within diagnosis. It
negates self-blame, but also negates the social and psychological factors within which depression is also situated.

As Miriam illustrated earlier, the initial reactions interviewees had to their diagnosis – such as feeling labelled, not knowing who you are anymore, relief and fear – were reactions to this biomedical model of depression. It is a testament to how influential the biomedical model has become that it has imbued itself within lay perceptions of what a diagnosis of unipolar or bipolar depression means, or at least what it means when one first hears the diagnosis applied to oneself. Various factors channel the individual towards a particular internalisation of her diagnosis. David Pilgrim and Anne Rogers note that there is disagreement as to which factors have the most influence, but that diagnosis exerts power over the individual’s identity is generally agreed upon among labelling theorists:

[f]or Scheff (1966) it is psychiatrists; for Goffman (1961) it is the family plus professionals plus the total institution. However, there is an agreement that, once labelled, this significantly alters the person’s identity and social status. Once a person is seen to have lost their reason, then they will never be quite the same again in the eyes of others (Garfinkle, 1956). They are stripped of their old identity and a new one takes its place in what Goffman calls a “status degradation ceremony”. Part of such a process then leads to the labelled person internalizing the new identity ascribed to them. (Pilgrim & Rogers, 1993: 17)

The widespread acceptance of the biomedical model, particularly for bipolar disorder, in turn acts upon the individual’s expectations of her condition. Clinicians, the media, literature, friends and family all contribute to the individual’s acceptance of her depression as chronic, such that it is difficult to tell whether depression is viewed as chronic because the individual has experienced it as severe and unrelenting, or because of the results of genetic studies she has read, or because the power of sociocultural attitudes and expectations influences and confirms a belief in its chronicity. Yet the women I spoke with described a mixture of reactions to the point at which a new identity was bestowed upon them, and certainly not all of them would have experienced it as a “status degradation ceremony”. There were several, for instance, who felt relieved. Moreover, the new identity was not always internalised and was at times rejected. Frances, for instance, voiced serious doubts about her diagnosis of bipolar disorder. Without accepting one’s diagnosis, it is hard to see how it can be internalised.

The reactions of the women I interviewed to their diagnosis show that they feel as though they have had a biomedical label thrust upon them – especially so for the diagnosis of bipolar depression. Bipolar depression’s even heavier biomedicalisation in the eyes of the public is cemented by the
belief that it is a genetic problem. That belief, in turn, contributes to the individual’s view that it is not possible to overcome bipolar depression. By promoting genes as the centre of control of the condition, the biomedical model also renders it inescapable in the individual’s eyes. As Zoe explains, “[i]f it’s just biologically caused then it’s not possible to cure, but it’s possible to prevent or alleviate rather than to cure”. Gina further explains, “I mean the problem is as long as the prevailing opinion is that it’s hereditary or it’s genetic, I don’t think I’ll be able to convince myself that I’m over it altogether”.

Emphasising the biomedical view of depression deflects blame and is commonly thought to act as a defence against stigmatisation. The National Alliance on Mental Illness uses brain images and genetic tests to depict mental illness as biological, and that because it is biological, no one is responsible for it and it therefore does not deserve any stigma (Dumit, 2003)⁶ (although recall that this approach turns out to have the opposite of its intended effect). Mike Bury (1982) argues that this is the biomedical model’s advantage – helping individuals to maintain a sense of integrity in the midst of the illness. However, emphasising a genetic basis for depression can be a double-edged sword, with the moral seduction of the model counterbalanced by the sense of autonomy it asks the individual to relinquish. The journalist Tracy Thompson illustrates this dilemma when she writes about her diagnosis:

[s]o I was sick. But this was my brain I was talking about, not my gallbladder or my kidneys. It had some mysterious property called “consciousness”. It produced behaviour, the sum total of which was somehow me. If I wanted to say simply that my brain was sick, I could stop there and disavow responsibility for that sickness – but if I did that, I would be giving up my idea of autonomy in the world. I would be simply a product of some chemical abnormality in a lumpy gray organ between my ears. (Thompson, 1995: 189–190)

Not only does the simplistic, popular notion of biochemical causation undermine perceived autonomy, but it can also give the impression that the condition is permanently ingrained and impossible to escape. Long-term follow-up studies indicate that positive outcomes in recovery are possible for individuals diagnosed with severe mental illness (e.g. Breier et al., 1991; Harrow & Jobe, 2010; Jobe & Harrow, 2010). Yet the biomedical model which has permeated popular perceptions of diagnosis paints a darker picture. As Comaroff and Maguire note, the biomedical model leaves us “especially bereft when we have to face events for which no rational explanation or remedy is forthcoming” (1981: 119). This point may explain why it is that although in theory a model of depression that places blame entirely on the individual’s social environment should
also have the effect of diminishing the individual’s sense of control, in practice it is easier for individuals to view themselves as passive in the face of chemical imbalances than as passive in the face of social stresses. In the case of a depression caused by social stresses, there is at least potential for rational explanation, and hence the potential for gaining control. (I explore this point in detail in Chapter 5.)

However, as illustrated in the preceding chapter, many individuals do not hold to just one view of depression and the biomedical view can be incorporated into one’s self-view in ways that do not necessarily contradict other views. This phenomenon is not unique to the women I interviewed. In a study conducted by Renata Kokanovic and colleagues (2013), individuals both adopted aspects of the biomedical view of depression and simultaneously resisted it – going to the doctor for help with personal problems (for lack of an alternative) and hoping for some relief of symptoms, but not anticipating that the doctor can help them solve the root causes of their problems which were situated in the social world. There is a similar tension when it comes to questions of agency. We saw that while some of the women I spoke with understood the biomedical model as a challenge to their ability to view themselves as agents, this was not the case for others. Suzanne McKenzie-Mohr and Michelle Lafrance (2011), in their study of women who had experienced depression or rape, also showed that women were eager to express agency while at the same time deflect blame for their experience. They understood themselves as both agents and patients rather than as either blame-worthy or passive victims. In the same way, an initial understanding or impression of one’s diagnosis in biomedical terms does not necessarily rule out a search for meaning or rule the person out as an agent in his or her journey out of depression.

On the one hand, the experiences recounted in this chapter support labelling theorists who contend that being labelled changes an individual’s identity and her status in the eyes of society. On the other hand, their experiences emphasise that it is not the diagnosis per se but the individual’s interpretation of that diagnosis which has the most salience for if and how it will be internalised. Sue Estroff and colleagues (1991: 361) make a similar point:

[our data suggest that individuals’ understandings of their problems, more than formal designations like a psychiatric diagnosis, have a strong influence on their views of themselves in relation to mental illness. Self-labeling, or seeing oneself as having a mental illness or being mentally ill, is clearly influenced by many factors, most of which are not clinical but contextual, experiential, and sociocultural […] Labeling theory thus overestimates the importance of these formal biomedical
designations, while failing to consider adequately how aspects of the person influence label acceptance or rejection.

Estroff and colleagues recount the racial and gender influences on self-labelling. I suggest that the individual’s beliefs regarding self-determination and responsibility also influence self-labelling. In both cases, what is apparent is that the overall impact of a psychiatric diagnosis on the individual is not a one-way process but the result of an interaction which occurs between the diagnosis and the meaning the individual ascribes to that diagnosis. This meaning in turn derives from the social interaction that the individual has with others (Blumer, 1969).

In the eyes of the women I interviewed, depression was viewed in medicalised terms at the point of being given that label. But the meanings the diagnosis has among different groups can be quite different, and the way an individual describes his or her symptoms can vary markedly from one culture to another. The Chinese, for example, are more likely to present with somatic symptoms than to speak about emotion (Kleinman, 1988b); in parts of India, they might be more likely to describe a fallen or painful heart (Pilgrim & Bentall, 1999); and in many non-Western countries, there is no word for “depression” (Kim, 2002; Marsella, 1980). Individuals may receive a different diagnosis (such as neurasthenia if they are in China) rather than depression (Kleinman, 1988b). A biomedical model may never be implied or assumed, and hence never internalised by the individual. The implications of the diagnosis may thus have an entirely different impact on people in different cultures.

Conclusion

The initial reactions of those I interviewed to their diagnosis revealed that they felt as though a biomedical model of depression was imposed upon them. As such, their reactions were based on what they felt the biomedical model meant for their sense of self. How and to what extent a diagnosis could impact on the individual’s sense of self largely hinges on the degree of self-determination and responsibility the individual believes the depression allows. Those who believe the diagnosis exonerates them from responsibility for depression feel relieved by their diagnosis. In contrast, those who fear stigmatisation fear the blame they might receive from people who believe depression to be a personal failing, or something an individual should be able to control. Being labelled with what one understands (at least at the point of diagnosis) to be a biomedical disorder also has ramifications for the individual’s sense of self by the implication...
that one has less self-determination. In theory, there is nothing to prevent certain thoughts and emotions from being both aspects of a psychiatric condition and aspects of one’s personality. But in practice, learning of a diagnosis that is interpreted as removing one’s responsibility for those traits also seems to challenge the place of those traits in one’s self. Removing responsibility for certain traits and behaviours also effectively removes them from within the individual’s control. As such, the biomedical model was a double-edged sword – removing responsibility for depression while simultaneously removing the prospect of having control over it.

Many scholars have criticised the biomedical model of depression for ignoring psycho-social factors surrounding and contributing to depression, and there is now scientific consensus that causes of depression are complex, not well understood and likely to involve a combination of biological, social and psychological factors (Murray & Lopez, 1996). This point even became the subject of Richard Bentall’s open letter to Stephen Fry concerning his BBC documentary series In the Mind (Bentall, 2016). Yet the biomedical model does more than that – it also indirectly contributes to the view of depression as a chronic condition. It does so by both diminishing the individual’s sense of self-determination and by putting forward a model of depression in which there are no exits. A belief that one has the ultimate power to change one’s thoughts, emotions and behaviours appears to be a prerequisite to being able to identify them as truly one’s own. This belief is influenced not only by how the individual interprets her diagnosis but also by how she interprets the role of medication.