Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940–2004

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For Missy, Bluey, and Birdy—
thanks for the adventure

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Preface

Each year, the United States and the United Kingdom spend billions to treat depression. Despite these costs, depression remains one of the most underrecognized, undertreated, and disabling conditions in both countries. At the same time, depression is one of the most common reasons that people seek care from generalist physicians; these primary-care doctors treat most patients suffering from depression. Unfortunately, advances in medical science have not led to a decline in depression in either country.

While new strategies for diagnosing and treating depression have improved millions of people's lives, there is little evidence that the overall societal burden of depression has decreased. In contrast, the application of public health techniques, coupled with antibiotic medications, led to a dramatic decline in morbidity and mortality from infectious diseases in industrialized countries in the twentieth century. Along the same lines, early interventions for the risk factors associated with cardiovascular disease precipitated a decline in morbidity and mortality from heart attack and stroke. Why have we not seen a similar decline in morbidity and mortality from depression? Most experts point to a gap between what psychiatrists *know* and what primary-care doctors *do* to explain untreated depression. We argue, however, that untreated depression is caused by a lack of attention to a public health perspective that would emphasize the role of individual and community responsibility.

The central premise of this book is that depression and the current treatment models associated with it are so narrowly defined that only a limited number of patients will seek and benefit from care. Current etiologic models that explain how depression progresses underestimate the roles of society and culture in causing depression and overemphasize biological aspects. These models are too deterministic and fail to reveal how much they have changed in the past 50 years.

This book emphasizes how the definition of depression has changed over time. The definition of depression which identifies it as an illness that explains emotional suffering, opens a pathway for seeking medical help, and offers a model for providing care is an invention that is less than a quarter-century old. In the 1950s, organized medicine had given emotional suffering other labels, ascribed other causes to it, and provided different treatments, which had replaced those from earlier in the century. The invention and reinvention not only changed medical terms and treatments but also changed how society views people with emotional symptoms, defines who is sick, and determines who should seek and receive care. Each reinvention also influences public decisions regarding who should pay for and who should benefit from providing care. The definition and treatment of depression are important inventions of science and society that enable us to care for people in need. The title of this book emphasizes that the invention is not static. It has changed frequently and will continue to change.

While we refer most often to "depression," the terminology of emotional disorders has been fluid, and thus our scope includes a broad array of affective or mood disorders. For example, much of the early work in this field dealt with emotional symptoms or diagnoses such as "neurosis" rather than with explicit psychiatric diagnoses as currently defined. In retelling this story, we adopt the language of each period that was used to label emotional disorders (Berrios and Porter 1995). These terms are not synonyms for "depression." It is also important to recognize that labels have consequences: The language of emotional disorders carries significant meanings and influences the behavior of patients, providers, and policy makers (Berrios 1985).

When referring to primary care, we use the following terms interchangeably: primary care, general practice, general health care, general medicine settings, general medical care, family practice, and family medicine. We also use the terms general practitioner, primary-care physician, family physician, and generalist to denote the physician working in the primary-care environment. While these terms are not necessarily interchangeable, their overlap in meaning and practice is so substantial that we treat the terms as synonyms in this book. In addition, public health experts often refer to primary care as first-contact health care. The World Health Organization (1978) defines primary health care as:

> Essential health care, based on practical, scientifically sound, socially acceptable methods and technology, made universally accessible to individuals and families in the community, through their full participation and at a cost the community and the country can afford. It

forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

To tell the broader story of depression, it is important to describe the story of scientific discoveries within psychiatry. We are arguing, however, that since World War I and especially since World War II, the story of primary care rivals psychiatry's importance in the care of depression. The current labels, causes, and treatments for depression are not the end of this process—they are simply the latest chapter. We can better understand the strengths and weaknesses of the latest reinvention by taking a historical perspective that includes changes in both science and society. Central to this historical perspective is the story of primary-care medicine.

Primary-care doctors provide most of the care for patients with depression. Experts do not debate this fact, yet the current, narrow approach to depression fails to take advantage of primary care's potential strengths. Chief among these strengths are the primary-care doctor's ability to manage the patient's entire constellation of medical conditions, to understand the broad context of the patient's emotional symptoms, and to enlist the patient and the community in prevention and treatment. Unfortunately, primary care does not effectively use this potential. Also, the primary-care profession and society remain ambivalent about expanding primary care's role to include the health of communities. This ambivalence stems from our discomfort in the ambiguous zone between public health mandates and personal liberty.

This book tells the still-unfolding story of why we seek and how we receive care for emotional disorders and how both science and society influence our decisions. We will not see progress in the care of depression until we understand where we are and how we got here. Ideas about the causes and treatments of depression have changed dramatically over the past half-century. Social viewpoints and world events have at least as great a role as scientific discovery has in precipitating these changes. Primary-care medicine is at the focal point of care for depression. Thus, the reinvention of depression plays out on the stage of primary care, and changes on this stage influence the reinvention at least as much as discoveries in psychiatry do.

Most books about the history of depression focus only on developments in psychiatry or psychopharmacology, failing to recognize the influential role of primary care. This narrower perspective also fails to integrate the advances in psychiatry or psychopharmacology with other medical discoveries and changes in the spectrum of human illness, and it ignores society's important role in modulating help-seeking behaviors for problems like depression. We embrace these complexities and thus present a more complete picture of the reinvention of depression.

Our challenge in organizing this book comes not from a lack of information but

from how to best communicate the intertwined histories in a readable fashion. In telling this story, we considered organizing the book as a strict chronology of events. That approach, however, would have exaggerated discrete events and distorted the incremental, interrelated, and serendipitous nature of the reinvention. To capture the broader perspective, we decided to focus on a series of six interconnected stories, each unfolding over the past 50 years. We start with a core thread and then successively weave in five more threads.

Six Interconnected Stories Describing the Reinvention of Depression Over the Past Half Century

1. How did primary-care patients seek help and how did doctors provide treatment for emotional symptoms during the past half century?
2. How has the primary-care environment changed and which social and scientific factors were important in causing these changes?
3. How did new drugs help change the nature of illness cared for by primary-care doctors and how did this change society's expectations for medical care?
4. How was psychiatry's transformed after World War II through the major discoveries in psychopharmacology?
5. How did primary care physicians develop a nonspecific approach to emotional disorders in primary care and what was the role of the pharmaceutical industry?
6. How have psychiatrists attempted to improve the specificity and effectiveness of treatment for depression in primary care?

The core thread is the story of how primary-care patients sought help and how doctors have provided treatment for emotional symptoms during the past half century. The second thread describes how the primary-care environment changed and which social and scientific factors were important in causing these changes. The third thread tells how new drugs helped change the nature of illness cared for by primary-care doctors and how this changed society's expectations for medical care, which, in turn, affected the role of primary-care doctors. These first three stories paint the picture of primary care because it is on this canvas that most people receive health care for depression.

After describing primary care, we take a step back in time to tell the fourth story about psychiatry's transformation after World War II and the major discoveries in psychopharmacology. This fourth thread is about patients with psychiatric conditions who receive care from specialty psychiatry rather than primary care (schizophrenia, for example). This is an important story because the disease-specific treatment model for these psychiatric disorders will eventually collide with the nonspecific treatment model for emotional disorders that are typical of primary care, which is the main theme of the fifth thread. This fifth thread also addresses the important role of the pharmaceutical industry, as opposed to psychiatry, in offering treatments for emotional disorders in primary care before 1975. It

is only in the last quarter of the twentieth century that psychiatry came to discover this new world of psychiatric morbidity in primary care. The sixth and final thread traces psychiatrists' efforts to improve the specificity and effectiveness of treatment for depression in primary care and how they attempted to disseminate this new model. Through these six intertwined stories, we outline the strengths and limits of the latest reinvention of depression.

Understanding these strengths and limitations helps us see why depression's burden on the community has not decreased. The current treatment model, which was developed by specialty psychiatry and accepted by primary care, reinforces the idea that we can treat depression in a relatively narrow, mainly biological way. This limited model fails to realize primary care's full potential. In most respects, primary-care doctors have either delegated or abdicated their leadership role in treating people with emotional disorders to psychiatric specialists, other health-care professionals, researchers, industry, and policy makers. Primary-care doctors limit their participation in research, practice redesign, and policy on emotional disorders. This is not a fault of psychiatry or the industry—rather, it points to a failure of primary care leadership.

The reinvention of depression in the past half-century indicates real progress. Yet if we do not expose the current model's assumptions, conventions, and limits, continued progress will be stalled. Primary-care doctors need not and should not receive treatment guidelines passively. Instead, they must embrace their central role in the care of patients with emotional disorders and in the continual reinvention of depression. Taking this role inevitably will lead general physicians to consider the multiple determinants of emotional health that currently remain outside the range of primary care, such as the social and physical environment, education, and economic opportunity, among others.

This expanding role for primary care will compel society to weigh the advantages and disadvantages of a primary-care system that increasingly concerns itself with community health. Primary care and society already struggle with these issues in such areas as lifestyle behaviors and preventive measures for cardiovascular disease, for example. Reinventing depression, however, may demand that primary care reach even further into difficult social problems. Depression may help reinvent primary care by pushing these boundaries. For this reason, we wrote this book not just for health services researchers and mental health specialists but for the larger community of providers, patients, and advocates who seek to improve the lives of people with depression through prevention and treatment.

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Contents

Part III Lessons Learned and Moving Forward

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Reinventing Depression

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Part I

THE CARE OF EMOTIONAL DISORDERS IN PRIMARY CARE

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1

WHY DEPRESSION?

Depression is a killer. It kills dreams, marriages, and people. As the history of reinventing depression unfolds, and as we recount the serendipitous discoveries and cultural conventions surrounding this illness, we do not wish to minimize the suffering that depression causes. No part of this history suggests that depression and emotional problems are not important public health concerns. To highlight the importance of depression from the very outset of this book, we first review recent information about both its global and its personal impact. We then present a general model for the causes of depression and outline the current treatment model for depression in primary care. The goal of this chapter, therefore, is to summarize the experience of depression in our communities.

The Burden of Depression

The World Health Organization estimates that 450 million people worldwide suffer from a mental illness and that one in four people will suffer from mental illness at some point in their lives (see Box, next page). Mental illness may account for as much as one-third of all disability (Murray and Lopez 1996; World Health Organization 2001). It is estimated that depressive disorders afflict 121 million people globally and account for 10% of all people seeking care from generalist physicians. Among patients with a major depressive disorder, as many as 15%