

# **At the Edges – A Place and A Space For Tears:**

## **Exploring the Framing of Depression in Contemporary Western Culture**

By

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# Abstract

In this thesis I explore the contemporary Western framing of depression as an illness requiring treatment. This understanding of depression is examined through a hermeneutic study of the depression literature, focussing primarily on medical and sociological academic literature, but also including one popular website. Drawing on Weberian social theory, I argue that the dominant cultural understanding of depression allows only one story to be told: that of depression as an illness necessitating medical treatment to facilitate a cure. However, depression can also be understood as part of the suffering that constitutes what it is to be human. While contemporary approaches to depression are valuable, they are also restricted. I suggest an inclusive interstitiality of different stories would expand the current framing of depression.

I draw on Weber's analysis of the causal and codified nature of Western rationality and of the total world-view of the secular West deriving from religious antecedents to analyse the current framing of depression. In addition, I employ Derridean concepts of the Western proclivity for logocentrism and Levinasian concepts of the Western impulse to change Other into Same to augment the Weberian analysis to demonstrate how dominant approaches to depression are influenced by both historical and cultural factors 'specific and peculiar' to the Western way of viewing the world. This approach embeds depression within the historical-cultural milieu of the West, which I argue provides a predominantly exclusive and scientifically based view of depression as illness. I demonstrate this through an exploration of historical influences, interpretative positions, the assigning of meaning, and information produced for the public. Finally, I proffer some possibilities for future directions.

The meta-perspective provided by this approach facilitates, for example, an appreciation that contemporary medical science inherited its belief in a total world-view from Western religious antecedents. Such a world-view results in the contemporary framing of depression functioning as though depression can *only* be viewed from the medical-scientific perspective, which is considered, *a priori*, to be the correct perspective. Establishing this meta-perspective enables the contemporary

framing of depression to be situated firmly *within* its historical-cultural background. Through this re-interpretation of contemporary approaches to depression the study provides another perspective on depression: one that is historically and culturally grounded, one that challenges current perspectives and opinions, and one that encourages respectful dialogue and debate.

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Hence loathèd Melancholy  
Of Cerberus and blackest midnight born,  
In Stygian cave forlorn  
‘Mongst horrid shapes, and shrieks, and sights unholy,  
Find out some uncouth cell,  
Where brooding darkness spreads his jealous wings,  
And the night-raven sings;  
There under ebon shades, and low-browed rocks,  
As ragged as thy locks,  
In dark Cimmerian desert ever dwell....

Mirth with thee, I mean to live.

(*L'Allegro*, John Milton)<sup>1</sup>

But hail though goddess, sage and holy,  
Hail divinest Melancholy,  
Whose saintly visage is too bright  
To hit the sense of human sight;  
And therefore to our weaker view,  
O'erlaid with black, staid Wisdom's hue....

And I with thee will choose to live.

(*Il Penseroso*, John Milton)<sup>2</sup>

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<sup>1</sup> Milton 2007: 15-19

<sup>2</sup> Milton 2007: 19-24

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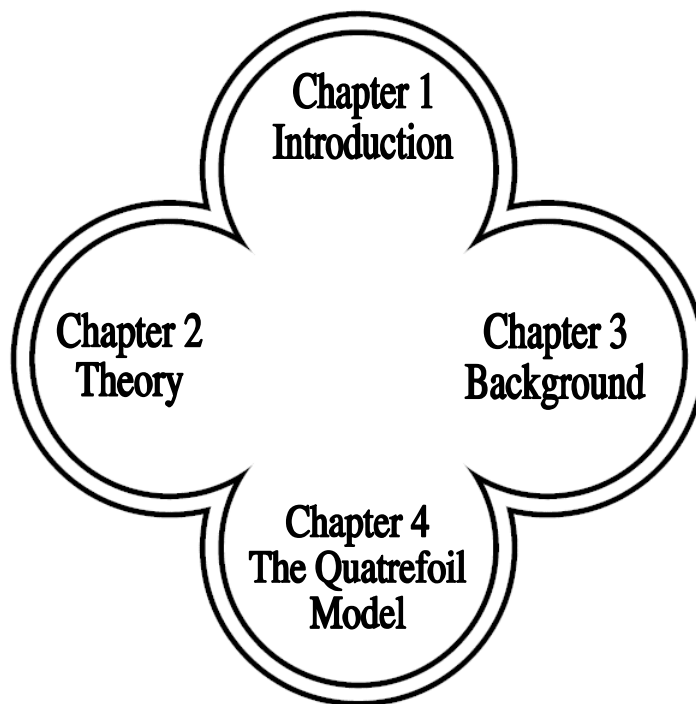
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## Part One

# Introduction and Background

There is no desire more natural than the desire for knowledge. We try every means that may lead us to it. When reason fails us, we make use of experience.... Reason has so many shapes that we do not know which to take hold of; experience has no fewer.

(Michel de Montaigne)<sup>1</sup>



**Chapter One** provides an overview of the thesis, an explanation of layout and approach, and an introduction to the topic.

**Chapter Two** gives a brief overview of the search for a theoretical framework suitable for the purposes of this study.

**Chapter Three** briefly examines the legacy in Western culture of a long association with various approaches to the problem of suffering.

**Chapter Four** introduces the theoretical model used in this thesis.

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<sup>1</sup> Montaigne 1958: 343-344

## Chapter One – Introduction

# Depression: Demon or Dæmon?

**Where there is sorrow there is holy ground.... For the secret of life is suffering.**

(Oscar Wilde)<sup>1</sup>

**[T]ell us, pray, what devil  
This melancholy is, which can transform  
Men into monsters.**

(John Ford)<sup>2</sup>

**Wherever you find men, you will also find suffering.... Deep down in the bowels of every man ... there sleeps a horrible, unclean larva. Lean over and say to this larva: ‘I love you!’ and it shall sprout wings and become a butterfly.**

(Nikos Kazantzakis)<sup>3</sup>

### 1.1 Introduction

This thesis is a journey of exploration and hope: an exploration of the contemporary Western framing of depression and a hope that such framing can be broadened to value and honour *all* perspectives on depression so that *all* who are engulfed by emotional suffering may find a ‘story’ that is supportive and meaningful. My study constitutes a meta-perspective on depression. It examines why contemporary Western culture has arrived at a particular juncture in its history where human sadness is regarded as an illness requiring medical treatment and the implications and consequences of this. Using concepts drawn from Weber, Derrida, and Levinas I explore the broad historical-cultural sweep, rather than the miniature of detail,

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<sup>1</sup> Wilde 1954: 143, 161

<sup>2</sup> Ford 1965: 52

<sup>3</sup> Kazantzakis 1962: 202

evident in the contemporary Western framing of depression. This framing is revealed to be culturally and historically situated. The research I have undertaken strongly suggests that an expanded framing would allow for inclusivity and the coexistence of differing opinion. Such an expanded framing would also facilitate potential growth and creative approaches to depression only possible when divergence converges in an interstitiality of respectful dialogue. In painterly terms, the *chiaroscuro*<sup>4</sup> (light and dark) of the ‘human portrait’ is dominated in the contemporary West by an emphasis on *chiaro*<sup>5</sup> (light), with *oscuro*<sup>6</sup> (dark) very much ‘at the edges’. In this thesis, I hope to demonstrate that the contemporary Western preference for *chiaro* over *oscuro* is both a product and an aspect of our history and culture and to suggest that today a broader palette, in facilitating a deeper rendering of the human portrait, would be inclusive of greater tonal variation.

This study, and the theoretical framework it utilizes, is not designed to produce either clear and absolute analysis or final and definitive conclusions. Those looking for pre-eminent analysis and magisterial conclusions will be disappointed. The thesis is a suggestive journey, not an incisive expose; it is an invitation to view things in a different way, not a conclusive, authoritative analysis; it is grounded in organicism, not structural steel; it seeks dialogic coexistence, not dialectical synthesis. I have sought an alternative way of looking at depression that both comments on the dominant contemporary paradigm and facilitates different paradigms. In particular, I propose a perspective on depression that allows for a wider and more inclusive understanding of depression in contemporary culture, one that is multidirectional, rather than unidirectional, and multivalent, rather than univalent.

## 1.2 Background and Overview

Contemporary Western medicine is an example *par excellence* of the rich and robust benefits and advantages of the scientific approach to the world. However, while it can appear that the enormous advances in medicine have greatly increased life

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<sup>4</sup> The word *chiaroscuro*, originally Italian, “is now used in English to describe the interaction of light and shade in two-dimensional art” (Preble & Preble 1989: 78).

<sup>5</sup> The word *chiaro* is from the Italian, meaning “light or clear” (Preble & Preble 1989: 78).

<sup>6</sup> The word *oscuro* is from the Italian, meaning “dark or obscure” (Preble & Preble 1989: 78).

expectancy and quality of life, it is in fact sanitation and better nutrition that are largely responsible (Freund & McGuire 1995), with only seven out of a thirty-five year gain in life expectancy due to modern medicine (Phillips 2008). Nevertheless, advances in medical capability and understanding continue at an almost dizzying pace. Medicine, particularly in the last hundred or so years, has increasingly pursued rigorous research and development in all areas of health and illness. At the same time, phenomenal advances in technology have both facilitated and worked in tandem with medical research to produce gargantuan leaps in diagnostic and treatment possibilities.

Psychiatry has transformed the victimization, stigmatization, and brutality meted out to the mentally ill in former times and brings a range of diagnostic and treatment options to care for the mentally ill. Indeed, the extent to which depression is now very much a part of public language and discourse is testimony to the profession's determination and commitment to improve treatment, to educate the general public and increase depression literacy, and to de-stigmatize depression. While concerns have been raised over the presence and influence of 'scientism'<sup>7</sup> in Western culture, the care of the mentally ill today represents a colossal advance, replacing centuries of superstition with scientific principles and processes. Nonetheless, there is much disagreement both within and without medicine on a variety of aspects, such as diagnosis, treatment, and treatment efficacy.

The dominant position of medicine in the contemporary West, as with all scientific disciplines, is directly related to the pervasive and potent, yet virtually invisible, presence of scientism. The benefits afforded by medicine are dependent on a particular way of seeing the world and the individual. Notwithstanding such benefits, in this thesis I argue that the medical perspective has unintentionally limited contemporary approaches to depression, and that such a limitation has implications.

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<sup>7</sup> The original meaning of 'scientism' was "'the slavish imitation of the method and language of science'" (Hayek, quoted by Popper 1972: 185). However, Popper (1972: 185) criticizes this usage and uses the term to refer to "the aping of what is widely *mistaken* for the method of science", while Habermas (McCarthy 1984: 41) uses 'scientism' to refer to the "belief in the exclusive validity of empirical science". Despite differences of opinion, 'scientism' is normally used today to refer to the view that scientific method and knowledge is equally applicable and valid across all areas of human life, learning, and understanding. It has also entered the language of the public domain and is defined in the *Shorter Oxford English Dictionary on Historical Principles* (Brown 2002: 2699) as the "[e]xcessive belief in the power of scientific knowledge and techniques, or in the applicability of the methods of physical sciences to other fields".

That is, questions are raised: is the fact that the medical paradigm of depression is hegemonic<sup>8</sup> in Western culture, and widely accepted as *the* way of approaching depression, due to its scientific (and therefore believed superior) nature or to the nature of a peculiarly Western way of looking at the world, interpreting the world, and assigning meaning? Science is not “free from presuppositions” and the value accorded to “diminishing suffering ... to the greatest possible degree” is a medical presupposition that, as with all scientific presuppositions, cannot be proven scientifically, only “*interpreted*” scientifically (Weber 1991: 143-144). Weber (1949: 110) considered that the “belief in the value of scientific truth is the product of certain cultures”, arguing that the “*objective* validity” of science arises from a “*subjective*” position that presupposes the “*value*” of its “*truths*” that are only available through science. While science provides certain ‘truths’, these are not the only ‘truths’ and nor are all ‘truths’ determined by and linked to scientific facts (Radcliffe 2004).

If the belief in the supremacy of the medical paradigm is actually characteristic of a Western way of looking at the world, rather than characteristic of its inherent supremacy, then this may be curtailing recognition and understanding of the true value and place of medicine. In the area of depression, such beliefs may be causing inadvertent problems for researcher, doctor, and patient. For example, dismissing or deriding research into alternative and complementary therapies for the treatment of depression may be pointing to characteristics of a Western orientation to the world that, in not allowing for ‘other’ world-views or perspectives, is expressed as the rejection of ‘other’ therapeutic approaches. Medicine can take us to many brilliantly beneficial and life-affirming places, but an examination of Western rationalist orientations to the world and to the individual reveals that there are places that medicine cannot take us to because these orientations demarcate the possibilities of where medicine can take us.

Medicine is responsible for a revolution in the way that depression is defined, diagnosed, and treated. Increasingly, however, concerns have been raised, both from

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<sup>8</sup> According to Gramsci’s definition of hegemony (Fontana 1993: 140) as “intellectual and moral leadership ... whose principal constituting elements are consent and persuasion”, medicine has clearly assumed “a hegemonic role to the extent that it articulates and proliferates throughout society cultural and ideological belief systems whose teachings are accepted as universally valid by the general population.”

within and without medicine, about such framing. Yet, such discussions often tend to focus on, and disagree about, what is considered incorrect or correct with the medical paradigm. These discussions raise important and valuable contributions. They point to failures and flaws, suggesting changes and improvements, or point to successes and values, validating existing approaches. However, they tend to focus on the contemporary narrative of depression virtually *de nouveau* rather than as embedded in Western history and culture, or they give little consideration to the ways that history and culture can powerfully influence the contemporary framing of depression. Following both medical and sociological research that does pursue the subject of depression from a broad historical-cultural base (Dowrick 2004, Blazer 2005, Horwitz & Wakefield 2007) my approach is concerned with the macro picture, focussing on the ‘ground’ from which the contemporary Western framing of depression has arisen and by which it continues to be influenced.

In this thesis, I suggest that another approach to depression would be to focus on the ‘why’ of depression (why do we think this way about depression?) in addition to the ‘what’ of depression (what is it, what causes it, and what are the best treatments / solutions?). One way to accomplish this is to use ideas drawn from Weber concerning rationality, secular modernity, and meaning, from Derrida concerning interpretation and meaning, and from Levinas concerning being and meaning. I primarily use Weberian concepts, augmented by Derridean and Levinasian concepts, to illustrate the value of situating the medical approach to depression in its historical and cultural context. In this way, it can be seen, in both its advantages and disadvantages, as part of the West’s continuing journey with human suffering, of which sadness forms one part. I suggest that the medical paradigm of depression is circumscribed; this is not because it is wrong, misguided, or incomplete but because its foundations rest on Western rationalism. By utilizing a Weberian framework of rationalities, my research demonstrates that while medicine has clearly improved knowledge about depression and public understanding of depression it does so, nevertheless, only from within the confines of Western rationalism that privileges a scientific-based rationality above substantive rationality.

Busfield (2001: 1) is particularly concerned that the increase in medical understandings of mental illness (neurosciences and pharmacology, *et cetera*) have



resulted in the ascendancy of natural causes at the expense of social processes, and that this therefore also pushes aside “any contribution from sociology to the understanding of mental health and disorder”. Busfield (2001) cites not only scientific advances in medicine as potentially diminishing the value of sociological research: also influential are the power of doctors in the fields of mental health and training and society’s inclination to favour medical explanations of mental illness (*e.g.*, faulty genes) over social deficiencies that could cause individual mental health problems. A few years later De Vries, with similar concerns, cautioned that medical sociology “was in danger of descending into a ‘slump’” (Nettleton 2007: 2409).

De Vries urges “reinvigoration” of medical sociology through risk-taking and creativity (Nettleton 2007: 2409), while Busfield (2001: 2) argues that what is needed is to “*re-think* the sociology of mental health”. In order that the contributions sociology can make to understandings of mental health and illness continue, Busfield (2001: 2) calls for identification of the “ways in which the relevance of sociology can be reaffirmed and its work advanced and, if necessary, redirected”. Rogers and colleagues (2007: 289) consider that “in re-thinking the role and place of a sociology of mental health there is a need to progress an independent and distanced sociology too”. From a different perspective, Pilgrim (2007) argues that future sociological research needs to concentrate on why psychiatric diagnosis has survived, rather than on what is wrong with it, and why depression, despite considerable difference of opinion and lack of clear scientific markers, survives as a generally accepted diagnosis of a mental illness. While empirical studies are a central part of sociological research, Nettleton (2007: 2409) emphasises the need to “*reflect* ... at an appropriate level of abstraction” about links between areas of concern and about what conceptual tools are required to do this. Research needs to be “theoretically engaging” (Nettleton 2007: 2412), and even risk being “considered by some to be ‘useless’” because it is unconnected to matters of policy or practice (Nettleton 2007: 2409, quoting De Vries). Similarly, Williams (2003: 149) is concerned that the close ties between epidemiology and a “sociology of health inequalities and social structure ... is missing the opportunity to bring the full possibilities of an historically-informed sociological imagination to bear on some of the major concerns of contemporary societies”.

Recognition of the need to explore new ways that sociology can contribute to the area of mental health and illness, the need to examine why psychiatric diagnosis has survived, the need to produce theoretically reflective and engaging research that may not be of an empirically practical nature, and the need to embrace an historically-based sociological approach underscore the thrust of this study in its stance of ‘re-thinking’ depression. My research, although not directly pursuing a macro level examination of the interrelationships between “subjectivity, cultural factors and social structure” (Pierret 2003), is a macro level analysis that offers an alternative perspective on the understandings of depression available in the modern West. In so doing, the thesis is suggestive of an alternative approach to depression for the future: one that is inclusive of broader options for the individual experiencing depression, thereby enabling a greater choice.

I have also been mindful, in particular, that perhaps some studies go too far in criticising medicine, or unfairly or solely criticising medicine, by pointing to its failures, problems, and limitations and not to its successes (Williams 2001). Similarly, studies characterizing doctors as intent on domination of the patient, rather than genuine health care, are as reductionist and overly simplistic as those characterizing doctors as benevolent (Lupton 1997). “There is a danger in all single-minded models – biological or social – for explaining mental illness” (Karp 2007: 228). Embracing complexity and plurality avoids over-simplification and facilitates inclusive approaches that both value and probe.

Sociological perspectives can sometimes be reactive to medical perspectives, and I suggest that research needs to both value and critically analyse the medical paradigm. Attacking and undermining the medical position is ultimately non-productive (Aronowitz 2008b). Indeed, caution is necessary in approaching mental illness as *only* a social construct or category that removes it from the lived reality of suffering (Busfield 2001, Karp 2007). The work of those like Szasz (1970, 1974, 1994), who see mental illness as a myth, can be extremely insightful, fascinating, and challenging in many ways. However, perhaps a more balanced and integrated approach that does not antagonize the medical profession is not only a more helpful approach but also a necessary approach in the future (Worthman & Kohrt 2005).

### 1.2.1 Terminology

Terminology concerning what is generally referred to by the generic term of ‘depression’ is complicated and fraught with, often, considerable confusion and intense disagreement. Terms such as sadness, sorrow, unhappiness, depression, depressive disorder, clinical depression, melancholy, dysthymia, affective disorder, and mood disorder are widely used, often without specific definition, even though there is absolutely no consensus on their respective meanings. Reactions to a recent book that examined in detail the whole problem of the definition of sadness and depression (Horwitz & Wakefield 2007) was highly applauded by some (Busfield 2008) and partially and pointedly criticized by others (Kleinman 2007). Positions taken regarding how depression should be defined, how it should be distinguished from normal sadness, and how to differentiate between different types / levels of depression often result in oppositional positions regarding diagnosis and treatment of depression, such as that seen in Australia between Parker and Hickie (see, for example, Parker 2007, Hickie 2007). Individual discussions about depression tend to be cogently argued; yet, in the bubbling nexus of contradictory opinion, critical evaluation, and sometimes harsh judgement they proceed in something resembling a divisive and confused muddle, and are influenced by it.

Since this thesis is concerned with ‘why’ we think what we think about depression, rather than ‘what’ we think about depression, I somewhat reluctantly decided against addressing the bewildering and vexed issue of terminology. Nor did I add my own definitions of these terms to an already confusing and contradictory milieu, as this would require tedious and repetitive clarificatory remarks every time I refer to research or express an opinion. I tend to use ‘depression’, but also other terms such as ‘sadness’. When using these terms I am referring to what could loosely be described as emotional suffering, which is part of the suffering constituting, in my opinion, the human condition. This thesis is not concerned with attempting to solve the problem of definition, nor to argue for the ‘best’ definition. If the experts in medicine and sociology are unable to agree on definitional parameters for these various terms, it seems reasonable that I accept this ‘divisive and confused muddle’ and proceed with my study regardless. In addition, I believe that this problem of definition is *actually* indicative of a problem of framing, which is precisely what this

thesis does explore. In a way, then, I *am* addressing the problem of terminology: I address it not by examining what the differences in definitions are, resolving these differences, and offering solutions but by examining *why* there are differences.

I also had to make a decision regarding the use of the terms ‘medicine’ and ‘medical’ versus ‘biomedicine’ and ‘biomedical’. Medical literature generally uses the former and sociological literature generally uses the latter. Sociologists tend to use the latter terms because they are seen to indicate the biological basis of modern Western medicine. On one level, this appears to be reasonable, and there is “general agreement” on the use of these labels in sociology (Quah 2003). However, medicine is actually “*more holistic*” than sociologists often give it credit for (Williams 2001: 141, quoting Kelly & Field). This presented an ethical dilemma for me. After considerable reflection I decided to adopt the terms ‘medicine’ and ‘medical’ in this thesis as I considered the other terms potentially divisive and pejorative because from the medical point of view medicine is not *just* biology.

The down side of this decision is that it concomitantly results in the assigning of the label ‘other’ to medicines not of allopathic origin. My decision could quite reasonably be argued as assigning a negative label to what is usually referred to as complementary and alternative medicine. This is certainly not my intention. Unfortunately, it was not possible to arrive at a solution amenable to all parties, which is why I seek in this thesis to emphasise respect and dialogic coexistence. Indeed, my ethical quandary reflects the unfortunate and unhelpful disputation that sometimes characterizes the relationship between medicine and sociology. As with definitional difficulties surrounding the use of the term ‘depression’, difficulties surrounding the use of terms ‘medicine’ and ‘medical’ versus ‘biomedicine’ and ‘biomedical’ are actually indicative of a framing problem. The choice of terms also reflects how health and illness are framed in the first place. In utilizing an historical-cultural approach to depression I seek to explore why depression is framed as it is, which may also facilitate an understanding of why there is such a demarcation in the choice of terms.

Finally, during the research and writing of this thesis I discovered that many of the sources I quote from (for example, Weber and some Weberian scholars) use the

terms ‘man’, ‘men’, or ‘mankind’ when referring to people or to humankind. In order to avoid the textual clutter caused by using ‘*sic*’ every time these words appear in a quoted reference I decided against using this practice. However, this should not be interpreted as agreement, on my part, with the use of sexist language.

### **1.2.2 Statement of the Problem**

Depression is a commonplace and conspicuous term in contemporary Western society, and is used by medicine to denote a mental illness considered by many to have reached epidemic proportions. Depression, worldwide, is viewed as a leading cause of disability (Andrews 2001, Peveler *et al.* 2002, Glass 2003, Mann 2005). Echoing this concern, Moussavi and colleagues (2007: 851) consider depression urgently needs addressing as “a public-health priority to reduce disease burden and disability, and to improve the overall health of populations”.

In comparison with other medical diagnoses, “depression is very common ... [and] occurs twice as frequently in women as in men” (Ebmeier *et al.* 2006: 153). Depressed people have been found to access health services more often (Ellis *et al.* 2004b) and to lead less successful lives than do happy people (Lyubomirsky *et al.* 2005). However, it is believed that the illness burden of depression and other mental illnesses is likely to be underestimated (Prince *et al.* 2007), and the level of unmet need is calculated to be an extensive global problem (Wang *et al.* 2007). Such a “silent scandal” (Thornicroft 2007: 808) requires increased resources (Wang *et al.* 2007), which is problematic given that the main obstacles to improving mental health are scarcity of resources, inequities, and inefficiencies (Saxena *et al.* 2007).

In Australia, depression is the most common mental disorder (Vos *et al.* 2005), and the level of suffering and cost to the individual and to the nation is enormous and needs “an urgent, national and coordinated response” (Hickie 2004). Despite claims from medicine that the causes of depression are at least partially understood and that it can be effectively treated (Ebmeier *et al.* 2006), there is disagreement about whether rates are actually increasing (Hawthorne *et al.* 2008), even though depression now accounts for one third of all general practitioner consultations (J.

Scott 2006). Although the medical emphasis is on expanding and developing neurobiological understandings of depression (Joyce & Paykel 2006, Joyce 2007), there are also voices from within medicine arguing that alternative approaches to the existing biological-scientific approaches are necessary (Dowrick 2004, Blazer 2005, Summerfield 2006b, 2006c).

Similarly, in the sociology of mental health and illness, where research has contributed to a growing understanding of the social causes, features, and issues of depression, there are also calls to re-conceptualize approaches (Busfield 2001). I suggest that exploring how the framing of depression in the contemporary West reflects specific aspects of Western history and culture provides a valuable and insightful perspective on depression, one not presently afforded by either medical or sociological approaches. This approach, then, facilitates a unique platform from which to ‘re-think’ depression. However, this study is not an attempt to re-theorize depression, or to create a new paradigm or a new model. Another ‘solution’ is precisely what is not needed. Rather, this study has embraced what I suggest is needed: an exploration of the framing of depression so that we can understand why and how ‘we are where we are’ with regard to this modern epidemic of depression and ‘where we can go from here’.

### **1.2.3 Sociological Research on Depression**

This thesis builds on the work undertaken in previous sociological research on depression that has significantly contributed to our understanding of depression. In particular, I seek to extend awareness of the diversity, complexity, and ambiguity surrounding the subject of depression identified by researchers such as Horwitz and Wakefield (2005, 2007), who examine the confusion of normal sadness with depressive illness, Karp (1996, 2001, 2007), who examines the stories of those whose lives have been affected by depression, and Williams (2000b), who raises issues to do with the dichotomy between reason and emotion.

Studies of the relationship of depression to particular social characteristics have demonstrated that depression is shaped by a variety of social factors and can be

approached from a variety of perspectives. For example, areas of depression research include a focus on: ethnicity (Coker 2003, Inaba *et al.* 2005, Kokanovic *et al.* 2008, Lackey 2008), gender (Nazroo *et al.* 1998, Bracke 2000, Brownhill *et al.* 2005), work (Ylipaavalniemi *et al.* 2005, Plaisier *et al.* 2007), social support (Heponiemi *et al.* 2006, Irwin *et al.* 2008), poverty (Meertens *et al.* 2003), volunteering (Musick & Wilson 2003), suicide (Coyle & MacWhannell 2002, Bennett *et al.* 2003), social status (Lincoln 2006, Olstead 2002, Sleath & Shih 2003), patient-doctor relationships (Malpass *et al.* 2009), media (Rowe *et al.* 2003), the elderly (Murray *et al.* 2006), young adults (Zimmerman *et al.* 2004), post-natal depression (Everingham *et al.* 2006), patient and carer stories (Karp 1996, 2001, 2007, and the medicalization of sadness (Shaw & Woodward 2004b, Horwitz & Wakefield 2005, 2007).

Other sociological research, while not directly focussed on depression, also contributes to depression research due to the related issues this research raises. Such research includes: an examination of evidence-based medicine (Bakx 1991, Barry 2006, Lambert 2006), an analysis of complementary and alternative medicine (Leiser 2003, Goldner 2004, Verhoef *et al.* 2006), the dichotomy between emotions and reason and the equating of health with happiness (Williams 2000b), a concern for suffering, meaning, and theodicy (Morgan 2002), a focus on the complexity of suffering and the need for a ‘sociodicy’ of suffering (Morgan & Wilkinson 2001), and a sociological approach to suffering that explores the possibilities of a sociology of suffering (Wilkinson 2005).

These few examples give an indication of the multiplicity of sociological research on depression, or related to depression and suffering, that is staggering in its breadth and depth, insight and analysis. I utilize such research extensively throughout this thesis, particularly in Chapters Five to Eight, and, because of this, I have not undertaken a separate literature review (as is usual in a doctoral thesis), as this would result in copious repetition. Corporately, this sociological research represents extensive and intensive work to develop and deepen our understandings of depression and suffering, substantially contributing to our knowledge base. While not wishing to elevate some as more worthy than others, my own research is, in particular, seriously indebted to some of these sociologists and the research they have undertaken. Their research is not only influential and important for this study, some is also pivotal and

crucial in directions that I took with my own research and in relation to issues of which I am particularly cognizant. By way of illustration, I detail several examples below.

Williams (2000b) presents a fascinating and insightful analysis of emotions and reason, health and illness. He argues that the demarcation between reason and emotion results in the alignment of positive emotions, such as happiness, with health and negative emotions, such as depression, with illness. This pathologizing of selected human emotions is now routinized, even though in some circumstances depression may actually be a healthy reaction, not a pathological reaction. Williams (2000b: 574) calls for the development of a sociology of emotions and reason, with an emphasis on the primacy of emotions and a focus on “emotional health”, rather than on mental health or illness. He considers this approach would combat the danger in sociological research of unintentionally perpetuating dichotomies between mind and body / reason and emotion caused by following the medical perspective that designates certain emotions as illness and others as healthy. My contribution to this call is an historical-cultural analysis of current approaches to depression to determine the factors leading to the dominance of reason in the West and the resistance towards certain negative emotions, such as depression.

I also found the research by Horwitz and Wakefield (2005, 2007) on the medicalization of sadness inspiring. They focus on assessing the circumstances and issues that have led to the problematic situation where an emotional state that would previously have been considered normal sadness is now diagnosed as depressive illness. In broad-ranging research they examine sadness and depression, how they are differentiated, how depression is defined and diagnosed, emphasise the normality of sadness and its “inherent part of the human condition”, and call for debate about the “momentous and scientific and moral issue” of how sadness, even intense sadness, should be viewed (Horwitz & Wakefield 2007: 225). My research is similarly concerned with circumstances and issues that have led to the present crises of depressive illness in the West, and also pursues an historical-cultural investigation. However, it specifically examines the contemporary framing of depression in terms of what has led to the form of this framing rather than what has led to the contents of this framing.



Pivotal to the direction of my research was a thought-provoking article by Morgan (2002) examining the relationship between suffering and theodicy. In this article, Morgan explores suffering and Western rationalism, and it was in this article that I came across the previously unrealised potential of utilizing Weberian concepts for the theoretical basis of my study. Drawing on Weber, Morgan (2002: 308, 319) explores what he sees as an “‘inverse’ problem of theodicy”, where, living in a world “‘disenchanted’ by reason, the problem of theodicy presents an intractable dilemma”:

[W]e cannot escape the ‘intellectualism and rationalization’ upon which the organizing systems of modern life depend.... The belief that all problems will eventually yield to the ingenuity of science has displaced the irrational and tragic with an epic vision of the *technical* perfectibility of the secular world.

For Morgan (2002: 320), this dominance of science results in a “deficit of meaning” and problems of adequately dealing with suffering and meaning. Following Morgan, I use Weberian concepts concerned with rationality and meaning to specifically examine the framing of depression in the contemporary West. Additionally, I make suggestions for addressing the problems caused by the dominance in the West of scientific rationality.

From a different perspective, Karp (1996, 2001, 2007) is concerned with the personal stories of those suffering from depression and of their families, and in influential research spanning almost a decade-and-a-half he has made a profound contribution to our understandings of depression. Karp gives voice to the experience of depression, seeing the people he interviews as ‘experts’. In facilitating the sharing of these intensely private stories, he has helped articulate what it means to deal with depression, highlighting the complexity, ambiguity, and diversity of the depression experience. In particular, he has revealed the processes involved in committing to taking medications and what this means, the relationship between drugs and identity and authenticity, and the struggles, hopes, and courage of individuals negotiating a life affected by depression. Karp’s research reveals that the depression experience, while characterized by certain themes and patterns, is not homogenous and precisely delineated; rather it is multifaceted and complicated. Following Karp, my research is also concerned with giving ‘voice’; however, whereas Karp achieves this through a focus on individual stories of depression, I focus on the contemporary Western story

of depression within which these individual stories exist. I undertake this by examining the framing of this larger story, and *why* and *how* it is now framed as it is.

Karp (2007: 228) admits to being “bothered by the confluence of forces that lead doctors to *routinely* medicate for life distress”. I, too, as with so many others, am bothered by this situation. My research is one attempt, focussing in one direction, to come to a greater understanding of this “confluence of forces”. It concentrates on one aspect that may help us understand why our Western culture now views emotional suffering and distress as an illness that requires medical intervention. While the wide variety of sociological research increases knowledge about depression from many angles, I feel the historical-cultural framing of depression could be fruitfully explored. To that end, I have specifically focussed on the antecedents in Western culture that impact on how we perceive, interpret, and assign meaning to depression. Without the vast and valuable sociological research already undertaken on depression, and other related areas, my research would be impossible; indeed, it *is* only possible because it builds on, draws from, and extends the work of many others.

### **1.2.4 Statement of My Argument**

Disagreements, contestations, and confusions often evident in the variety of approaches to, and understandings of, depression can be seen either as problematic or as an opportunity to explore depression from a wider, inclusive framing. In this thesis, my argument is concerned with factors that have contributed to the way depression is framed in contemporary Western culture. The research is motivated by a strong sense of absence and complexity – something is missing in both the contemporary Western medical approach to depression and the sociological research about depression and the subject itself is far more complex and contradictory than is generally admitted. I suggest that contemporary approaches to depression are not so much wrong (indeed, many are valuable and useful) as indicative of significant characteristics in the framing of the discussions themselves. Further, it is this framing issue that also largely contributes to both the heated or non-existent dialogue between the different paradigmatic positions and also contributes to explaining the continuing rise of depression not only in the West, but worldwide. I have focussed

my discussions on the West because a study of this size precludes consideration of other cultures and their histories; much of what I say, however, can be applied worldwide because of the increasing global spread and dominance of Western culture.

Discussions concerning the various beliefs (ideas, approaches, paradigms, explanations) about depression are worthwhile projects, but I suggest that discussing what lies behind these beliefs (the historical-cultural phenomena) is also worthwhile and seminal in elucidating our understandings of depression in the modern West. It is not a ‘re-thinking’ of depression, *per se*, that is needed but a focussed ‘re-thinking’ of why we think depression is an illness. This directs analyses and discussions of depression through the clarifying lens of historical-cultural framing. However, my study of the framing of depression in contemporary Western culture proceeds on the caveat that I acknowledge that depression can be severe, causing immense suffering. In responding to this, medicine has made profound and valuable progress of a psychiatric-scientific nature in treating such depression and in de-stigmatizing depression in the wider community, and sociology has also made valuable contributions of a social-scientific nature in expanding our understandings of depression.

This thesis points to, and demonstrates, gaps in contemporary approaches to depression. These “‘inconvenient facts’” (Weber 1991: 147) are evident in the disagreements and conflicts about depression within medicine and between medicine and other professions. They are also directly broached or hinted at in the work of an increasing number of writers from various fields as they struggle to make sense of the escalating problem of depression in the Western world. I suggest that these ‘inconvenient facts’ are all symptomatic of a ‘specific and peculiar’ problem; that is, they are symptomatic of “the specific and peculiar rationalism of Western culture” (Weber 2001: xxxviii). Using Weberian concepts of rationality, expanded and enriched by some Derridean and Levinasian concepts, I argue that these gaps are signals – sometimes noisy, sometimes quiet, but always valuable and potent with possibility. They are indicative not that we have failed to understand depression but that secular modernity tends to restrict our understandings of it to illness, thereby effectively removing it from the realm of suffering that is part of our human

condition. However, following Weber, my argument, while pointing to the limitations, and subsequent problems, inherent in the Western rationalist approach to depression, also recognizes its benefits. Finally, I suggest that the framing of depression in the future would greatly benefit from being inclusive, rather than exclusive, in a way that allows for, and legitimates, ‘a place and a space for tears’ in the modern secular Western world.

### **1.3 Methodology**

This thesis is a sociological study that has employed a methodology largely drawn from the tradition of hermeneutics to explore how depression is framed in contemporary Western culture. As with my theoretical approach (see Chapters Two and Four) and method (see 1.4), the methodology developed in an organic process responding to need and discovery. In particular, my methodological approach is strongly influenced by an ethical concern for inclusivity and respect and a practical concern for undertaking a study concerned with revealing broad historical-cultural understandings of depression.

In justification for this approach I note that Busfield (2001: 9) draws attention to the importance of both qualitative and quantitative work in sociology, and laments the antagonism between these different types of research: “What we need are both theoretically-informed critical thinking and sound empirical work”. In addition, while methodology is crucial and central to any research, there is a recognized need for sociological research to develop new and alternative approaches (Busfield 2001) and to develop broader qualitative and quantitative methods and techniques and “alternative frameworks of understanding” (Williams 2003: 149). There is also a need for sociologists to be inclusive of “seemingly unconventional theoretical and methodological approaches” (Lawton 2003: 23) and to “strive to be more creative and ‘playful’ with ... work and ideas” (Nettleton 2007: 2409). My methodological approach, in ‘developing’ in process rather than being adopted from pre-existing types, resonates with such comments.

Further, Frank (2000: 355) argues, following Levinas, for the primacy of ethics in sociology over the primacy of methodology:

Social science needs methodology, but to afford priority to the methodological is to risk becoming one of the specialists without spirit whom Weber (1958) saw inhabiting the iron cage. Methodology must develop from a preoccupation with ethics lest it reinforce the iron cage.

Likewise, I also assign considerable importance and priority to ethics over stringent preoccupation with methodology. Pursuing “an *ethics as first sociology*” (Frank: 2000: 355) ensures I approach my topic and produce a thesis that encourages an ethic of respect for different ‘stories’ of depression and emphasises dialogue between different narratorial positions. My methodological approach is informed by these ethical considerations. Indeed, this thesis itself is inspired by an ethical priority and concern to tell a different ‘story’ about depression as a way of seeking both to understand the origins of the contemporary Western framing of depression, and its effects, and to suggest how this framing might move towards a greater inclusivity.

In telling this ‘story’ of depression, the selection of methodology was also determined by selecting the most appropriate way to furnish a meta-perspective on depression. The use of interviews, whether of health professionals or of the general public, was unsuited to the nature of research focussed on broad cultural understandings. Rather than amassing primary data consisting of individual ‘cameo portraits’ of depression I was interested in utilising published material that could provide ‘aerial reconnaissance photographs’ of the ‘depression terrain’. During the early phases of my study I decided that undertaking textual analysis of existing texts would best facilitate these research objectives. Hermeneutics, therefore, provided the most suitable methodology for my purposes of interpreting the texts to see how depression is understood.

By a hermeneutic methodology, I mean an approach that examines individual texts, and groups of texts, as indicators of broad cultural trends and patterns. My use of published texts to identify cultural trends situates my methodological approach in research that utilizes interpretation of texts. For example, in the field of sociology Weber (2001), Frank (1997), and Giddens (1993) employ an interpretative textual

analysis to reveal broad historical-cultural understandings of, respectively, the Protestant ethic, illness, and intimacy. In other disciplines, textual analysis is used to examine changes in the cultural understandings of happiness in the West (McMahon 2006), the relationship between poetry, society and the human condition from the ancient Greeks to the present (Parini 2008), and how the meaning of life has been interpreted in Western culture (Eagleton 2007). While I chose to focus on a theoretical approach based largely on Weber, rather than on hermeneutical theorists such as Habermas, Heidegger, or Gadamer, my study, nevertheless, constitutes a type of hermeneutical endeavour in its emphasis on interpretation. This hermeneutic approach, however, is representative of only one part of the multi-layered and ongoing investigations into the world that constitutes the complexity of hermeneutics (Ormiston & Schrift 1990). In addition, by employing triangulation (Neuman 1991), although of a non-standard type, in my theoretical model, I was able, through its five interrelated orientations, to research my topic from a number of different angles to gain a broad historical-cultural understanding of depression.

Of crucial importance in achieving this approach was how I justified the choice of the bulk of textual data to use in my interpretative research. In selecting peer-reviewed journals in medicine and sociology, I was able to ascertain from this data the broad cultural framing of depression communicated by these academically and culturally accepted understandings of depression. Focussing on interpretation facilitated an investigation of themes and patterns in the texts (Kellehear 1993) that enabled me to connect my method to my research aims of exploring the broad framing of depression, of situating it in a historical-cultural context, and of relating it to Western approaches to suffering.

Also useful to these tasks were aspects drawn from other methodologies. From ‘content analysis’, I employed demarcation of categories for content and time period (Kellehear 1993). In the selection of articles on depression, given that my interest is on broad understandings of depression, I excluded those concerned with depression and other illnesses (such as depression and heart disease) or those highly specialized (such as depression and trauma). The sample of journals selected was determined by Impact Factor (as per the Web of Science Journal Citation Reports) and was restricted to articles published since 2000 (see 1.4.1) because my focus is on the

framing of depression in contemporary Western society. The depression website (*beyondblue*) examined in Chapter Eight was selected as representative of campaigns worldwide to educate the public about depression and improve depression literacy (Parslow & Jorm 2002) and on the basis of its national focus and leading status in Australia (Griffiths & Christensen 2002). I also employed aspects of ‘thematic analysis’ in that in my research I developed my “theories / understandings by inductively attending to the data and its source”, by looking for “themes, patterns”, and by noting “differences and similarities”, particularly where “patterns in the data resemble theories / concepts” (Kellehear 1993: 38, 40).

While the majority of medical and sociological texts reveal certain understandings of depression that determine the contemporary framing of depression in the secular West, some of these texts and texts from other areas reveal alternative understandings. My approach seeks to interpret these parts with reference to the framing of the whole. In addition, in attempting to stay “close to the emic (insider’s) view” (Kellehear 1993: 39) at the same time as critiquing such views I try to engage respectfully with them in an approach grounded in ethics. I particularly focus on medical literature (in Chapters Five to Seven) as it is the strongest influence on contemporary understandings of depression and is the clearest expression of such understandings. For the same reasons, in Chapter Eight I focus on *beyondblue* because, as Australia’s “national depression initiative” (*beyondblue* website: Homepage), it furnishes understandings of depression provided to the public by the health professionals that constitute the contemporary cultural framing of depression in the West.

My study, however, is only one ‘story’ of depression. While my methodology has facilitated a particular interpretative examination of depression through material selected to gain an insight into the broad historical-cultural understandings of depression, this thesis represents only one avenue of research and interpretation. Other methodological approaches to depression furnish other ‘stories’. My study constitutes, then, but *one* interpretative response to the subject of depression: as Gadamer argued, “there is no such thing as *the* correct interpretation ... [because] interpretation is always a hermeneutic mediation of different languages ... [and] the

notion of a final, once-and-for-all interpretation makes no sense” (Dallmayr & McCarthy 1977: 288-289).

## **1.4 Method**

This study is a textual analysis, with data drawn from medicine, sociology, popular literature, websites, and literary / historical sources. It is a macro study in which I explore the broad historical-cultural brush strokes evident in the contemporary framing of depression, not the fine detailed brush strokes. The data used in this thesis is not exhaustive, but is representative of current approaches to depression. I was interested in the general cultural understandings of depression that this material reveals, and selected sufficient examples from various sources to undertake this exploration.

### **1.4.1 Data Collection**

My method of data collection for this thesis combines a review of academic literature on depression, examination of a variety of books and websites on depression, and perusal of material from other sources pertinent to my topic. My primary method of academic data collection for this thesis, which is also my literature review, was via the eJournals and Databases resources available through the University of Tasmania Library. The majority of the data collection and analysis for this study, while not entirely sequential, consists of five main areas: the medical literature on depression; the sociological literature on health and illness generally; the sociological literature on depression and on mental health and illness; literature about depression produced for the public (focussing on the website *beyondblue*); and literature from a variety of sources, largely literary / historical, concerning the Western approach to suffering. Together, these five areas constitute the sources of the bulk of data used in this thesis and are explored in Chapter Three and Chapters Five to Nine.

Firstly, I examined the world’s leading medical journals (determined by Impact Factor from the Web of Science Journal Citation Reports). I selected *The New*



*England Journal of Medicine*, *JAMA (the Journal of the American Medical Association)*, the *Lancet*, and *The Archives of General Psychiatry*. I also included *BMJ (British Medical Journal – International Edition)* as a balance to United States dominance. To provide an Australian component, I also included the *MJA (The Medical Journal of Australia)* and *The Australian and New Zealand Journal of Psychiatry*. In addition, to be sure of adequately covering the psychological approach to depression (even though this is well covered in the medical literature) I also selected the three most influential psychology journals (also by Impact Factor): *Annual Review of Psychology*, *Psychological Bulletin*, and *Psychological Review* as well as the *Australian Psychologist*.

I searched these journals using the terms depression and mental depression, excluding articles dealing with depression and other illnesses (such as cancer or diabetes) or specialized areas (such as post-natal depression or manic-depression). Overall, I limited my search to articles published from 2000 to 2005/6, and later updated my research to the end of 2008. My aim was to gain an overview of the current medical position regarding depression, and from this to ascertain the main themes about depression. This search provided a representative picture of the medical approaches to depression and their points of agreement and contestation. In total, I selected 255 articles (*The New England Journal of Medicine*: 30; *JAMA*: 22; *Lancet*: 17; *BMJ*: 72; *MJA*: 47; *The Archives of General Psychiatry*: 15; *The Australian and New Zealand Journal of Psychiatry*: 35; *Annual Review of Psychology*: 4; *Psychological Bulletin*: 4; *Psychological Review*: 2; *Australian Psychologist*: 7).

The articles I examined consisted of a variety of published material, such as trial reports, clinical reviews, articles, supplements, editorials, commentaries, personal views, letters, and book reviews. I initially organized material and wrote up my findings at length under the headings of diagnosis, causes, treatment, efficacy, education and public awareness, and future research, as these seemed to be the primary categories used in the medical literature when discussing depression. These headings also reflected the focus and areas of interest discernable in the literature. I then applied my theoretical model to these findings, with continual reference back to the literature itself.

Secondly, I examined the *Sociology of Health and Illness* and *Social Science and Medicine* to determine sociological approaches to health and illness generally. I was specifically interested in what sociologists had to say about the dominance of the medical paradigm in relation to health and illness. I undertook this search using the terms of medicalization, medicine, and evidence-based medicine (EBM) as my starting points, adding further terms, such as professionalization, surveillance, risk, and power, as these emerged as useful search terms from my initial searches. I sought an overview of what sociologists were thinking and researching. When I began duplicating my finds I decided that sufficient trawling of the literature had been achieved. I limited the search to articles published from 2000 to 2005/6, except where an older article (from the late 1990's) seemed particularly pertinent to my overview.

In all, I selected 75 articles. I read and re-read each of the articles a number of times. In writing my detailed overview of this literature I organised the main emergent themes of individualism, medicalization, professionalization, EBM, power, text, public shaping of science, surveillance and risk, illness narratives, chronic illness and pain, disability, and genetics under the broad headings of scientism, consumerism, and individualism. These themes and headings result from my own interpretation of the main concerns and thrusts of argument and research. Although only some of this material (51 articles) is referred to in my final thesis, all of it provided, nevertheless, a broad and useful background to my research.

The third step in my method was to re-examine these same journals (*Sociology of Health and Illness* and *Social Science and Medicine*) for any articles published since 2000 about depression and mental health and illness, which was later updated to 2008. As with the health professional literature review, I was not interested in depression associated with other illnesses or of a specialized type. I searched using the terms, depression and mental depression, and mental illness and health. In all, I read 54 articles (17 on mental health and 37 on depression).

I examined these articles a number of times and found the same sorts of themes emerging that I had found in my examination of the sociology literature about health and illness generally. I initially organised my research under the same themes for

ease of comparison. In the lengthy writing up of my research, I also subsequently grouped these thematic sections under the broader headings of scientism, consumerism, and individualism. I then applied my theoretical model to these findings, while also constantly referring back to the literature itself. To check I had not missed any important literature from these journals I also searched via the Sociological Abstracts database and found the same articles being duplicated. In addition, I also read a number of general sociology texts on health and illness, mental health and illness, and depression. These provided further background information about the main concerns, issues, approaches, and research areas in the field of sociology.

In my fourth step, I examined four of Australia's leading depression websites (Griffiths and Christensen 2002): *beyondblue*, *Black Dog Institute*, *BluePages* and *CRUFAD* (*Clinical Research Unit for Anxiety and Depression*). I also studied a number of books produced for the general public about depression. Most of this material, particularly the websites, was examined later in my doctoral candidature for its content as it related to what I had found in the medical and sociological literature. I was interested to discover in what ways the content of this material reflected content in literature from the academic domain and in what ways it differed. In my final writing up, I focussed on *beyondblue*, as I found it representative of material about depression produced for members of the general public.

Finally, in a process that spanned most of my doctoral candidature, I explored literary / historical sources for approaches to suffering. From the vast plethora of material available, I made selections based on their ability to clearly demonstrate, whether overtly or indirectly, an engagement with questions about suffering and the human condition. There are numerous texts that would have admirably served such criteria and from these I chose two representatives from Western antiquity, an ancient Hebraic text and ancient Greek ideas concerning tragedy, and two selections from the contemporary West, secular-atheistic literature and Christian hymns and songs. I avoided producing either a history of medical or literary approaches to sadness as these are already well researched (e.g., Horwitz & Wakefield 2005, 2007, Kleinman 2007, Wilson 2008). I read this material very closely to identify any commonality of themes about suffering and discovered an extraordinary perpetuity in

the identified themes. From these identified themes, I constructed a set of ‘motifs of suffering’ against which I situate my study of the Western framing of depression.

In the course of my research, I was sometimes alerted to the existence of other material that seemed pertinent to my topic. Where possible I obtained these articles or books for examination or perusal, depending on whether I found them directly or only tangentially related to my area of study. Nevertheless, such serendipitous encounters were sometimes an invaluable source of material; indeed, it was through such a meandering route that I discovered the potential value of utilising Weberian ideas for the theoretical foundation of my study.

In the process of writing the final drafts of the chapters (see Chapters Five to Nine) in which I applied my theoretical model (see Chapter Four) to the data I had examined I decided to focus on the medical material on depression, referring to the sociological material where applicable to, or useful for, my discussions. My reason for adopting this approach was that the medical paradigm of depression, despite internal disagreement and contestation, is not only dominant in the contemporary West it actually *constitutes*, in a very real sense, the contemporary Western framing of depression. External parties, such as governments, policy committees, pharmaceutical companies, and health care insurers, do unquestionably influence medicine. However, it is medicine, in a complicated weave of interrelationships with these external parties, which provides the foundation from which they in turn exert their influence over medicine and society as a whole. My study therefore, necessarily concentrates on the medical position because it drives and determines, far more than the sociological position, the contemporary framing of depression in the West in all its woven complexity. To take any other approach, such as evaluating the sociological and medical literature equally, would be to blatantly ignore the reality of medicine’s hegemonic position in the contemporary West.

## **1.4.2 Process**

The process utilized in this study was a multi-track journey into theory selection (see 2.2), development of methodology (see 1.3), and data collection. Although I began

my research with an interest in the virtual absence of spirituality in approaches to depression, and had planned to use Derridean textual deconstruction, I also explored a number of other possibilities. As with choosing a theoretical framework, data collection and assessment of possibilities proceeded down a number of interesting routes, even though most eventually proved to be dead-ends for my purposes.

For example, I examined the possibility of comparing psychiatric approaches to depression from the early 1800's with today by using archival material housed in the Tasmanian State Archives and in the University of Tasmania's Morris Miller and Clinical libraries. For a time I considered the idea, following Szasz (1970), of approaching the contemporary Western framing of depression through an examination of the correlation between medicine and the Inquisition in their denoting of 'other' as abnormal or evil, respectively. I also explored the idea of an historical examination of allopathic and homœopathic approaches to depression compared with contemporary approaches. Another possible direction was to examine past psychiatry textbooks compared with contemporary psychiatry textbooks, but discovered that, unfortunately, when the Royal Derwent Hospital<sup>9</sup> was closed all the old books were discarded. However, after a number of 'trawling expeditions' to identify if data collection was viable I decided against these potential directions as a way of exploring my topic of depression. In addition, I also looked at approaching my topic in the area of the sociology of chronic illness or disability, looking specifically at narrative and meaning. I was particularly interested, inspired by, for example, Kleinman (1988), Karp (1996), Frank (1997, 2000), Ezzy (2000), Bury (2001), and Dowrick (2004), in the value and possibilities of using narrative as a method of data analysis and as a way of approaching the subject of depression.

The whole research process was exciting, if at times tedious and frustrating, as I pursued paths not originally intended or even imagined. It was also sometimes frightening and unsettling as I allowed the material to take me in unplanned directions, rather than attempting to fit material into predetermined boxes. In hindsight, I can see that there was a particularly synergistic relationship in my

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<sup>9</sup> Under various names, the Royal Derwent was a hospital / asylum for the "in-patient treatment and rehabilitation of mentally ill and handicapped persons" from 1827 until its closure in 2000 (Archives Office of Tasmania n.d.).

research between methodology, method, and theory as I moved backwards and forwards between data, rationale, process, method, theory, and purpose before finally establishing my own theoretical model from which to examine the data through a hermeneutic methodology. Without this convoluted and organic process in my method, as well as in my methodological and theoretical approaches, it is unlikely I would have produced this study as it now stands.

## **1.5 Approach and Layout**

In this thesis, I begin by exploring responses to suffering in Western culture before examining the textual data to reveal how depression is framed in contemporary Western culture. I then draw these two explorations together against a background of material concerned with coexistence, plurality, and respect to investigate how a future framing of depression might evolve.

The thesis is composed of three main sections. In Part One I introduce the thesis (Chapter 1), lay out the theoretical background of the thesis (Chapter 2), examine Western responses to suffering (Chapter 3), and then introduce my theoretical model (Chapter Four). In Part Two I examine the medical and sociological literature on depression using this theoretical model (Chapters 5 -8). Finally, in Part Three I discuss the possibility of an expanded framing of depression (Chapter 9), and conclude my discussions (Chapter 10).

## **1.6 Conclusion**

My research and approach in this thesis stem from three sources: a shamelessly unbridled and life-long fascination and inquisitiveness about how history and culture influence every aspect of our lives; a life-long personal struggle with melancholic moods and anxiety culminating in two-and-a-half years of unsuccessful medical treatment for my diagnosed illness of depression; and, arising from the interaction between these first two sources, something of a bellowing in my ears questioning

why Western culture views depression as it does and whether there might be another way of looking at depression.

Following those such as Barry (2006), Frank (1991, 1997) and Karp (1996, 2001, 2007) who openly disclose personal associations with their topic of research, I acknowledge that my lifelong experience of depression indicates a clear and direct association between my personal life and my chosen topic of research. In addition, my negative experience of the medical treatment I received for my depression left me, to the say the least, rather antagonistic towards medicine. However, after my initial focus on spirituality as a missing dimension in the medical paradigm of depression (heavily influenced by my ‘anti-medical’ feelings), I moved strongly away from any position that focussed solely on a condemnation of medicine. I quickly realized that such an approach would be decidedly unhelpful. Acutely aware of the problems caused by divisiveness between different perspectives within Christianity (my own religious world-view) and between different religious world-views, I determined that my study of depression would not intentionally add to any divisiveness in ongoing research about depression. Instead, I hope it promotes open and respectful dialogue, where an ethic of dialogic debate and inclusivity replaces dialectical condemnation and exclusivity.

This thesis is a journey of exploration about emotional suffering, that today is termed ‘depression’: into what has gone before, into what is now, and into what may come in the future. It is a meta-investigation that is neither definitive nor conclusive, but suggestive of a different way of understanding the framing of depression in contemporary Western culture. I find the current ‘story’ of depression to be, because of Western rationalism, both valuable and restrictive and suggest that an interstitiality facilitating the respectful coexistence of different ‘stories’ about depression would enrich our understandings of depression in the future.

The human portrait, to return to my earlier painterly analogy, has historically shown a waxing and waning of *chiaro* and *oscuro* in different combinations and relationships (see Chapter Three). However, my research indicates that there is a particular preference in the contemporary Western framing of depression that seeks to paint the human portrait largely in *chiaro*, by resisting *oscuro*. This preference has

led to a ‘specific and peculiar’ painting style, which would benefit, I suggest, from the use of a broader palette, thereby facilitating the enriching of this portrait in a vibrant and potent mix of light and dark.

Suffering defines a part of what it means to be human, affecting a person physically, mentally, and emotionally. As one facet of human suffering, I consider it would be to our detriment as a species if we were to *only* rationalize sadness as a depressive illness and control it through drugs and other therapies. Viewing the suffering of sadness as an illness called depression is one ‘story’, but there are other ‘stories’ that speak to what is ‘beautiful’ and ‘valuable’ in such emotional suffering. Some can even see butterflies arising from the “horrible, unclean” (Kazantzakis 1962: 202) depths of human suffering. I am not disputing that depression can be something terrible and painful, but I am suggesting that a wider perspective than that of only illness would allow for other ways of engaging with such emotional suffering. In the West, ‘a place and a space for tears’ is neither spatial nor temporal. The places and spaces are, and always have been, in process; and the contemporary West currently seems to be at a critical juncture in place and time to substantially enrich this unfolding journey of our relationship with sadness, with the emotional suffering that constitutes a part of our human condition.

Depression is both demon and dæmon<sup>10</sup>, both “loathed” and “holy” (Milton 2007:15-24). In their respective emphases on melancholy and mirth (sadness and happiness, night and day, dark and light) evident in Milton’s *L’Allegro* and *Il Penseroso* can be seen reflected aspects of the Motifs of Suffering in Western culture explored in Chapter Three and the orientations to depression in Western culture introduced in Chapter Four and explored in Chapters Five to Nine. Between the polarities in Western culture of viewing sadness as “holy ground” (Wilde 1979: 54) or as “devil” (Ford 1965: 52) are to be found the numerous concerted efforts, however different, to understand and enrich the continuing human journey with what it means to be emotional beings who feel pain. I think this study, with its specific focus on

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<sup>10</sup> I am using these words according to their conventional definitions (Brown 2002: 638): demon as an “evil spirit ... or an unclean spirit” and dæmon, also spelt daimon, as “an attendant or indwelling spirit, one’s genius” reflecting ancient Greek and late Middle English usage. The former, then, is something essentially bad and the latter is something essentially good. In application to depression, I am conveying the sense that depression is both terrible and destructive, robbing a person of life, value and meaning (depression as demon), and also ‘beautiful’ and creative, instilling profundity, meaning and possibility into a person’s life (depression as dæmon).



depression, in some small way represents a modest example of Busfield's (2001:2) call for sociologists to "*re-think*" the sociology of mental health and illness. It is also a study that is deeply indebted to the sociologists and philosophers from whom I have so brazenly and eclectically commandeered their profound, brilliant, and insightful ideas. In the next chapter, I map my convoluted journey into theory, discussing the ideas of three theorists on whose concepts my approach to depression in this study is based.

# Chapter Two

## Theory: Possibilities and Directions

**Try again and again to formulate the theories which you are holding and to criticize them. And try to construct alternative theories – alternatives even to those theories which appear to you inescapable; for only in this way will you understand the theories you hold. Whenever a theory appears to you as the only possible one, take this as a sign that you have neither understood the theory nor the problem that it was intended to solve.**

(Karl Popper)<sup>1</sup>

**A single thought is that which it is from other thoughts as a wave of the sea takes its form and shape from the waves which precede and follow it.**

(Samuel Coleridge)<sup>2</sup>

**For theory is something which is made, no less than its object.... It is a practice of concepts, and it must be judged in the light of the other practices with which it interferes.... It is at the level of the interference of many practices that things happen....**

(Gilles Deleuze)<sup>3</sup>

### 2.1 Introduction

In this chapter, I give a brief overview of my search for a theoretical framework, and then introduce and discuss the selected theorists (Weber, Derrida, and Levinas) and their ideas that I utilize. I explored a variety of theoretical directions, any of which would have provided valuable characteristics upon which to draw for the development of a theoretical position. Consequently, establishing a theoretical basis was a convoluted journey, characterized by organic growth. Without such a journey, comprising frustrating dead-ends, interesting detours, and unexpected surprises, my

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<sup>1</sup> Popper 1972: 266

<sup>2</sup> Coleridge 1864: 68

<sup>3</sup> Colebrook 2002: xliv

theoretical approach would have been far poorer. For example, it was only in the course of pursuing other theoretical possibilities that I stumbled over the previously unrealised possibilities of utilizing Levinas's ideas concerned with Other and respect and, much later, of Weber's ideas about rationality and Western rationalism.

During the course of my reading and research, I became increasingly persuaded that aspects of Weber's work could provide a powerfully revealing perspective on the Western framing of depression. Indeed, I found the possibility so striking that my gaze was re-directed from my original plan to use Derrida to a re-focussing largely on Weber. Weber's ideas provide a millennial (*i.e.*, a meta-temporal) perspective that allows for the isolation of characteristics that a more limited temporal study may miss. The application to my area of study of Weber's broad cultural analysis and the historical aspects he identified as crucial to understanding Western secular modernity has been an exciting, challenging, and rewarding endeavour.

## **2.2 Background**

The theoretical framework for this thesis stems from three sources. One comprises characteristics (the areas of interest and concern) I discerned in the depression literature I read. The second draws on the ideas of theorists and scholars I examined for a theoretical approach. The third source constitutes my evolving purpose that began as an idea to use deconstruction to explore spirituality and depression. After much research and exploration, this pursuit of a theoretical direction for my study finally metamorphosed into the aim of establishing a theoretical basis focussed on the characteristics lying behind what is discussed in the depression literature and on facilitating plurality of viewpoint. The nexus of these three sources eventually coalesced into the construction of a theoretical model of historical-cultural framing that fused my original, yet developing, interests in using interpretation, narrative, and liminality as a means for studying depression (see Chapter Four).

At the commencement of this study, before beginning my research of the depression literature in detail, I had initially thought of employing Derridean concepts because

of my interest in using deconstruction and interpretation. Nevertheless, I soon embarked on what turned out to be a lengthy exploration of a variety of other options to see if anything else would theoretically facilitate my interests, or variations thereof. One of these possibilities was to examine medicalization through the rise and dominance of medicine in the West and its relationship to the place of complementary and alternative medicine (Freund & McGuire 1995, White 2002, Tovey *et al.* 2004). Other potential avenues in the medicalization approach included a focus on power and medical dominance (Foucault 1971, 1980, Freund 1982, Willis 1983, 2006, Tassano 1995, Turner & Samson 1995) or on individualization (Honneth 2004). Another interesting direction was risk, including the areas of risk, surveillance, and reflexivity (Giddens 1990, 1991, Beck 1992, Petersen & Lupton 1996), risk and cultural theory (Douglas 1992), risk and therapy (Furedi 2004), or risk and public health (Petersen & Lupton 1996).

In addition, I delved into a variety of approaches and findings from the sociology of health and illness (Tuckett & Kaufert 1978, Conrad & Kern 1981, Schwartz 1994, Freund & McGuire 1995, Petersen & Waddell 1998, White 2002, Shaw and Kauppinen 2004) and from the sociology of mental health and illness (Brown & Harris 1978, Prior 1993, Pilgrim & Rogers 1999, Busfield 2001) to determine if any of these offered or suggested insights or possible theoretical perspectives that I might find useful for my study of depression. Furthermore, once I had commenced reading the depression literature, both medical and sociological, I started to become specifically familiar with a variety of existing approaches to depression. This research helped fuel my intent of finding another way of approaching depression.

Other potential avenues I explored for determining an alternative theoretical perspective included the relationship between religion or spirituality and health, including mental health, (McGuire & Kantor 1987, McGuire 1990, Koenig 1998, 2003a, Swinton 2001, Peach 2003a); between suffering and modernity (Morgan & Wilkinson 2001, Morgan 2002, Wilkinson 2005); between postmodernism (or modernity or high modernity) and health and illness (Giddens 1990, 1991, Fox 1993, 1998); and between narrative and illness (Kleinman 1988, Frank 1997, Kelly & Dickinson 1997, Ezzy 2000). Embodiment and the regulation of health and illness (Lupton 1994, 1995, Turner 1996a, Williams & Bendelow 1998, Broom 2001) and

chronic illness (Strauss 1981, Conrad 1987, Toombs *et al.* 1995) provided some further possibilities in my search for a different theoretical approach to depression.

Given my interest with deconstruction and interpretation, I also briefly and tentatively assessed the possibility of utilizing a theoretical perspective from the complex and contested areas of either postmodernism (Abbinnett 2003) or hermeneutics (Schrift 1990, Ormiston & Schrift 1990), since they reflected a combination of concerns with the relationship between the power of science and technology and the place of the individual in the modern secular world. For a short time, I also perused two other possible directions: Deleuze and Guattari's (1988) extraordinary and challenging philosophical explorations, that are not so much philosophical arguments as the radical formation "of a new way of thinking" (Colebrook 2002: xviii); and Habermas's interest in the dangers of "scientism" (McCarthy 1984: 41, quoting Habermas) and "technocratic consciousness" (Held 1980: 254). Additionally, I was later interested in Habermas's re-drawing of Weber's thesis of rationalities and in his critique of Weber's approach to, and structuring of, occidental rationalism and its inherent problems for Western society (Habermas 1984, Pusey 1987). Another interesting option, because of his approach to culture and history, that I dipped into, primarily via Habermas (Habermas 1977, Pusey 1987, Gadamer 1990), was Gadamer's fascinating concept of 'horizons'. Alexander's (2003) promotion of the 'strong programme' based on structuralism and hermeneutics also furnished interesting sociological research perspectives on the interrelationships between culture and history.

This long journey in search of theory eventually developed into a specific focus on historical-cultural framing and interpretation and brought me to a clear emphasis on Weberian concepts of rationality and meaning. I made this choice based on a growing sense of the value of Weber, augmented by Derrida and Levinas, in facilitating my abiding interest in finding another way of looking at depression. This choice was also determined in part by the size restrictions of a doctoral thesis, in which I found I was unable to pursue as much, and in as much detail, as I had originally planned. However, what started as the direct application of some of their ideas to my topic of depression evolved into the creation, drawing on these selected ideas, of my own theoretical model of historical-cultural framing (see Chapter Four).

## 2.2.1 Selected Theorists

The ideas of Weber, Derrida, and Levinas have been widely utilized across disciplines ranging from sociology to philosophy to cultural studies to linguistics. A central characteristic of their work is a concern with how humans make sense of their world: how they see their world and seek to order and master that world, how they interpret that world, and how they assign meaning to that world. For these reasons they are particularly valuable for my study. I use Weber's ideas concerning the transformation of religions, the Protestant ethic, and Western rationalism. In addition, I also refer to Derrida's ideas concerning Western patterns of interpretation and meaning and Levinas's concepts surrounding the nature of being.

The concepts of all three theorists are extremely complex and complicated and are often difficult to read and understand. Therefore, while a more comprehensive use of their work would be beneficial, for a study of this size I have restricted my scope and utilized only certain aspects of their work to a specific end. Moreover, any engagement with their ideas is beset by the same problems inherent in any situation where texts are read in translation (and, therefore, also interpretation). Recently, for example, several new translations of Weber's *The Protestant Ethic and the Spirit of Capitalism* (by Baehr and Wells in 2002, and Kalberg in 2008) have drawn attention to the powerful influence that translators can exert over the reception, understanding, and future research implications of their translations. Nevertheless, interpretation, whether via translation or not, is itself a salient characteristic of research and work with translated texts does not necessarily detract from the resulting research or its contribution to ongoing debate.

Whether seen through the Weberian total world-view and Western rationalism or Derridean logocentrism and the Rousseauistic Interpretation or the Levinasian impulse to change Other into Same, there is in the West a paramount proclivity to attempt to control and master the world. All three theorists encourage recognition that it is often how and why a perspective or paradigm is dominant that informs most about what is occurring, and why such dominance has come about in the first place. They draw attention to characteristics of Western thought that manifest as the need to interpret and explain in order to control. By first understanding this impetus, where it

comes from and how it functions, an alternative perspective on the Western framing of depression is facilitated. In addition, all three theorists also draw attention to the need for respect and responsible action.

## 2.3 Weber

For in all cases ... it is a question of the specific and peculiar rationalism of Western culture. (Weber 2001: xxxviii)

Many old gods ascend from their graves ... and again they resume their eternal struggle with one another.... Our civilization destines us to realize more clearly these struggles again. (Weber 1991: 149)

Weber, as one of the founders of the social sciences, “is probably the most challenging and intellectually complex figure” and his “vast opus of detailed historical, economic, and social-political investigations is a stunning illustration of the ‘sociological imagination’” (Dallmayr & McCarthy 1977: 19). From a reading of even some of the work of Weber and of some Weberian scholars it is to be concluded, as acknowledged by many of these scholars themselves (*e.g.*, Mommsen 1974, Brubaker 1984, Lash & Whimster 1987, Gerth & Mills in Weber 1991), that Weber’s ideas are complex, difficult to understand, fraught with problems of translation and interpretation, sometimes apparently contradictory, scattered throughout his work, and incomplete. Indeed, Turner (Weber 1991: xii, referring to and quoting Gallie) refers to Weber as a pre-eminent example of an “‘essentially contested’” author, where interpretation of his work “gives rise inevitably and endlessly to controversy”.

Nevertheless, Weberian thought, particularly concerning rationality and Western rationalism, is a rich source for a wide array of scholarship concerning modern life and the place of the individual, ranging from personal conduct to the irreversibility of Western rationalism to rational action to politics and reason (Lash & Whimster 1987). Some scholars seek to both critique and explore Weberian concepts, though with differing emphases and interpretative stances: this can be seen, for example, in

the work of Schluchter on rationality and religion (1987, 1989) and on rationality and history (1981), Brubaker (1984) on Weber's diagnosis of rationality, Kalberg on rationality, rationalization and history (1980) and on comparative history and sociology (1994), and Turner (1996) on fate and the individual in the modern world.

Other scholars seek to specifically extend Weber's ideas: such extensions are undertaken, for example, in areas such as instrumental rationality and anomie (Orrù 1989), development of a multi-dimensional concept of rationality (Genov 1991), the link between formal and substantive rationalities in organizations (Stinchcombe 1986), and the relationship between society and rationality in development of the McDonaldization thesis (Ritzer 1993). Still other scholars value Weber's ideas but seek to re-frame some Weberian concepts: they pursue such endeavours, for example, by juxtaposing Weberian thought with that of other theorists (Sica 1988), by substantially dismantling and then reconstructing Weberian concepts of rationality, ethics, and meaning (Habermas 1984), or by re-examining Weberian interpretations of the individual and institutions (Lachmann 1970). There are also scholars who are particularly critical of aspects of Weber's thought: they argue, for example, that his concepts of formal and substantive rationality are confused and biased (Eisen 1978), that there are substantial difficulties with Weber's concepts of values and ends in terms of causality (Swidler 1986), that the division between means-end and value-rationalities is flawed (Wallace 1990), and that he has misinterpreted the relationship between instrumental rationality and the individual as a rational actor (Hindess 1991).

The continued variety of interpretation and approach to Weberian theories and to the place of the individual in the modern West suggests that Weber's concepts provide fertile and valuable ground for continued use, application, analysis, critique, and extension. Moreover, it is this variety of approach that contributes to sociology's strength because if "sociology is to remain healthy as a discipline, it should be able to support a theoretical pluralism and lively debate" (Alexander 2003: 26). Despite any inherent problems in understanding Weber's theories and the various interpretative stances and contestations taken by Weberian scholars, Weber's ideas provide a unique way of examining the nature and functioning of society in the



contemporary West. Commenting on Weber, Schluchter (Roth & Schluchter 1979: 13) observes that:

his sociology is not only ... the “articulated problematic of reality itself”; his problems are at least partly still ours and have not been resolved.... Weber achieves a diagnosis of our situation on the basis of his socio-economic, political, and socio-cultural analyses of capitalism and of occidental rationalism. It is the diagnosis of the disenchantment of the world..., the diagnosis of the rationalization of its value spheres and the intellectualization of our responses to them. But it is also the diagnosis of the paradox of this process, which presents to modern society a problem not only of management but also of meaning.

Schluchter’s comments point to the value of Weber’s diagnosis of Western secular modernity because it is drawn from his analysis of historical-cultural developments that have led to the characteristics that define the contemporary West, and it also recognizes the paradoxical relationship between meaning and Western rationalism.

Roth observes that in his work, “Weber wanted to identify the causal concatenation that for over two and one-half millennia has led to the present rationalized world” (Roth & Schluchter 1979: 187), a process that Weber saw as “a history of various ‘factors’ coming together in an unlikely but reinforcing” sequence (Roth 1987: 88). It is this meta-perspective that furnishes valuable causal links and concepts that enable the possibility of discussions to be situated firmly *within* the broad historical-cultural milieu from which they have arisen. The importance of Weber’s thought was that he always related his work to the future and it “was his still unsurpassed knowledge of the past history of human societies which gave him an acute perception of the key issues of his own age” (Mommsen 1974: ix).

“Weber’s impact on social science and social theory has been profound and complex” (Dallmayr & McCarthy 1977: 5). His ideas are “a ‘huge quarry’ of suggestive concepts and intriguing hypotheses that remain to inspire new reflections upon the ways in which people create meanings for and out of their social experience of the world” (Wilkinson 2005: 65, referring to and quoting Käsler). This thesis results from inspiration derived from a ‘mining’ of Weber’s ideas to create a theoretical framework that facilitates a different way of approaching depression and

the study of depression in the contemporary West. While a variety of cultural sociological approaches that proceed from a criticism of Weberian concepts and arguments could have been utilized (*e.g.*, Eisen 1978, Swidler 1986) I decided, following Weberian scholars such as Schluchter (1981) or Brubaker (1984) or Kalberg (1994), that Weberian ideas as they stand still furnish salient and profitable theoretical possibilities for understanding secular modernity.

Weber posits three useful insights (the transformation of religions, the Protestant ethic, and Western rationalism) that I consider particularly pertinent in formulating understandings of Western society that are only possible from an historical-cultural perspective. Such a broad view explicates the relationship between history and characteristics of contemporary Western culture. The theoretical foundation of this study of the Western approach to depression is drawn largely from Weberian thought because it considerably enhances an historical-cultural analysis of antecedents to the thinking behind aspects of secular modernity.

### **2.3.1 Historical Religious Antecedents**

Based on his three-stage model of the transformation of religions, Weber considered that secular modernity in the West exhibits both the plurality of indigenous<sup>4</sup> religions and the singularity of the total world-view of universalist religions, as well as the universalist religious emphasis on codification and rules (Schroeder 1987). Weber identified three stages: the indigenous or polytheistic religion, characterized by competing gods, universalist or monotheistic religion, characterized by a single god, and secular modernity, characterized by a decline in the place of religious god(s). In particular,

the transition from the primitive or magical form of religiosity to Judaeo-Christianity means that.... the world of plurality of magical forces is now replaced by an all-encompassing conception of the divine, codified and administered by the priestly elite.... [and] a single, all-embracing system of values. (Schroeder 1987: 209)

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<sup>4</sup> Weber (as read in translation), and some Weberian scholars, use the terms 'primitive' or 'magical', when referring to indigenous religions. I will use this latter term as today 'primitive' or 'magical' could be construed as having unwanted and unacceptable connotations that may be disrespectful to those practicing indigenous religions.

In the contemporary West, the plurality of competing gods (different value spheres) and the singularity of one god (a dominant world-view) function in tension with each other, despite the lapsing of its religious origin. Weber (1991) saw the resulting tension between different value spheres, such as that between the religious and the intellectual spheres, as an “irreconcilable” (147, 152) conflict between the “old gods” (148-149). The transference of inner orientation and belief in world-mastery from the religious to the secular worlds, primarily since the Enlightenment, has profoundly coloured the modern Western world. Also transferred from the universalist religious stance into secularism was the emphasis on codes and rules, the authority and power of the religious priest transferring to the secular professional.

### **Total World-View**

Both the Christian and secular world-views “claim to be total world views” from which meaning can be attributed to the world, with the secular world-view having displaced the Christian world-view as the dominant one in the Western world (Schluchter 1989: 257). The beliefs that there is a single and all encompassing way of viewing the world and that the world can be mastered are defining tenets of the modern Western world-view, both inherited, minus the religious basis, directly from its Judaic-Christian heritage. Science proceeds from the presupposition that it represents “the only possible form of a reasoned view of the world” (Weber 1991: 355). Both the secular and the religious make the same claim of a total world-view:

Both suggest an ultimate position through which they attribute meaning to the world.... Each will define the other as the carrier of a partial world view, which at best can offer a limited interpretation of the world. (Schluchter 1989: 257)

In Western secular modernity, this belief in a total world-view causes tension between its former religious total world-view, Christianity, and its ‘newest’ total world-view, science. Tension arises because, inevitably, total world-views are going to clash. Although political and religious tensions and their problems are arguably the most serious in terms of humanity’s future, nevertheless, there are also, I suggest, significant and far-reaching problems evident in the total world-view of science and its dominance in the secular West, and increasingly worldwide.

While science, particularly since the Enlightenment, has increasingly furnished causal explanations for phenomena in the natural world, the adoption of science as the total world-view from which to understand and explain the world is a belief, an act of faith. From a Weberian perspective it is not simply that the scientific / secular world-view ‘replaced’ the Christian religious world-view, but that the *idea* of a total world-view was transferred intact from Christianity to science. For Weber, “[s]cience ... is itself a religion” (Roth & Schluchter 1979: 50). It is characterized, as with any religion, by “‘presuppositions’”, and such scientific presuppositions cannot be proved “by scientific means” but only “*interpreted*” with reference to the scientific perspective (Weber 1991: 143). Following Weber, Whimster (Lash & Whimster 1987: 260) attributes the mythic status and role of science in Western culture to precepts within Christianity linking cognition and belief:

The reason for the prevalence of this myth lies in precepts of Christian civilization that have exerted such a close, albeit troubled, association between what we know and what we believe. Once the boundary from a religiously understood world to a scientifically understood world was crossed, religious belief lost its centrality in terms of the way in which the world was seen. However, so strong were the links between cognition and belief that science was perforce made to carry a prescriptive burden, which very simply meant that there was an expectation of a scientific answer to every sort of question.

The transference from the universalist Christian world-view to the scientific / secular world-view involved a transferring verbatim of the cultural framing of *how* to relate to the world, minus the religious ‘whys and wherefores’. In other words, that we believe the scientific world-view to be ‘total’ and ‘true’ is because the Christian world-view was believed to be ‘total’ and ‘true’.

Weber argues that the dominance of the beliefs in a total world-view and world-mastery in the Western secular world stem from a peculiarly Western way of viewing the world transferred from Christianity. Hence, in a peculiarly Western circular argument that is entirely self-referential, science considers its world-view and world-mastery as resulting from the presumed self-evident superiority of science. Weber identified aspects of Western culture as arising from a particular way of looking at the world that involved a fixation on one perspective to the exclusion of

other and competing ones. His ideas contribute to explaining the transformation from the Christian world-view to the secular / scientific world-view and, most importantly, explain why the dominance of science seems ‘natural’ and ‘right’.

## **Pluralism**

Secondly, Weber considered that the secular world-view also exhibits the pluralism of indigenous religions, which is brought about by the declining influence of religion in the West (Schroeder 1987). Weber saw the different value spheres in secular modernity as “warring gods” (Weber 1991: 153). He suggested these differing spheres, such as the political, the intellectual, and the religious, are in conflict with each other, none more so than the intellectual (scientific) and the religious. In secular modernity these “old gods ... are disenchanted and hence take the form of impersonal forces” (Weber 1991: 149). They struggle with each other for dominance in our lives, “over which human beings have little effective control” (Turner 1996b: 47). The disenchantment of the world, resulting from the rationalism of the modern West, has produced an acute level of conflict (Schluchter 1981), but Weber stresses it is “[f]ate, and certainly not ‘science’, [that] holds sway over these gods and their struggles” (Weber 1991: 148).

In the same way that the ideas of a total world-view and world-mastery transferred from Christianity to Western secularism, so science has also inherited the Christian illusion “that ‘polytheism’ can be overcome” (Roth & Schluchter 1979: 51, note 139). The presence of such beliefs at the same time as the “old gods” are ascending “from their graves” (Weber 1991: 149) contributes to the secular beliefs that science *is* the total world-view and *will* overcome threats to its dominance and control. This occurs despite the presence of conflicting value spheres and, particularly, the continuing conflict between science and other values. In the West, the supremacy of science as the total world-view is maintained on the basis that other perspectives (particularly the religious or New Age alternatives) are inferior, despite the proliferation in recent decades of alternative spiritual and life-style options and orientations. The belief in the triumphalism of Christianity over polytheism has transferred to the belief in the triumphalism of science over other perspectives.

While Weber recognized that historically polytheism inevitably involved conflict between different gods, he considered that the distinctiveness of the conflict between the different ‘gods’ of secular modernity, between the different value spheres and world-views, had intensified (Schroeder 1987). It is the combination of the universalist belief in a total world-view *and* the indigenous religious belief in plurality that produces this increasing intensification of conflict between values in the modern West. Weber saw this conflict as extraordinarily complex and “irreconcilable” (Weber 1991: 147, 152). This situation, in which there is neither “hierophanies nor any impulse for the transcendence of self” (Schluchter 1989: 274), evoked for Weber the image of the “iron cage” (Weber 2001: 123).

For Weber the world has been “disenchanted and denuded of its mystical” qualities and each person has to choose between conflicting gods and “decide which is God ... and which is the devil” for themselves (Weber 1991: 148). Therein, for Weber, lies “the fate of the times” (Weber 1991: 155): living in a society that, because it is undergirded by beliefs in a total world-view and world-mastery which are continually undermined by pluralism in every sphere of life, demands choice between competing and conflicting alternatives. In other words, contemporary Western society is characterized by singularity and plurality: there is ‘one’, but there are also ‘many’, and each person, in all areas of life, is required to choose.

## **Elites**

The third aspect that the secular contemporary West inherited from its Judaic-Christian heritage is the universalist pre-occupation with codes administered and controlled by a ruling elite (Schroeder 1987). With the waning of the religious base, this world-view is expressed in the modern West as a secular / scientific conception of the world dominated by laws, rules, regulations, and codes all created, controlled, and managed by professionals in various fields of expertise. These value spheres of modern life function, in effect, independently of each other:

[They] operate in relative autonomy according to their own laws, satisfying man’s need for calculability of the world to an historically unparalleled degree. This calculability rests on the

confidence that in principle one can count on the rules of these spheres. (Roth & Schluchter 1979: 54)

As with the transference of a total world-view from Christianity to secularism, the place and power of the priest in Christianity transferred to the place and power of the professional. The proliferation of areas of expertise in all facets of life (medicine, law, *et cetera*) controlled by professionals is representative of this transference of interpretation and control of the world. With respect to health and illness, there “appears to be a general process whereby the body ceases to be a feature of religious culture and is incorporated via medicalization into a topic within a scientific discourse” (Turner, 1987: 225-226).

In addition, as in Christianity, where the Church hierarchy controlled the education of those entering the priesthood, various professional bodies control, or at least influence, those who are selected to train for the professions, how they are trained, who qualifies, and, most importantly, who are registered to practice these professions. Control over what is published in the professional journals is also exerted by the professions themselves. Understanding the historical / cultural antecedents of the contemporary Western emphasis on professions provides a valuable perspective in also understanding why it seems ‘right’ that professions should not only have dominance in their fields, but also dominance politically and socially. Weber drew attention to the characteristics of the secular world inherited from its Judaic-Christian heritage as a powerful combination of a monotheistic total world-view and a codification of life by elites existing within a world of re-emerging polytheistic plurality.

### **2.3.2 The Protestant Ethic**

Weber’s (2001) thesis of the Protestant ethic furnishes a number of insights pertinent to an understanding of secular modernity because they are concerned, as with the religious antecedents, with the developmental causality of characteristics of Western modernity. The Protestant ethic is “important to our understanding of the origin and character of the occidental ethos” (Roth & Schluchter 1979: 42) in its rejection of irrationality, focus on vocation, and denial of emotions.

The emphasis in Protestantism, particularly Calvinism, on asceticism and rationality has transferred, without the religious ethic, to contemporary Western culture. In the Protestant ethic's rejection of the world, expressed as domination of the world, is revealed the type of rationalism "which is part of the ideational underpinnings of modern society" (Roth & Schluchter 1979: 42). Weber considered the rationality of the Protestant ethic "lay in its inner consistency, in the self-conscious rejection of magical and emotional elements of religion, and in sober devotion to duty and methodical self-control" (Morgan 2002: 308). For Weber (2001), Protestantism was particularly instrumental in the rationalization of the West. Protestant "worldly asceticism" (Weber 2001: 107) unintentionally provided the disciplined internal impetus that, once the religious basis had waned, also contributed to the development of the "specific and peculiar rationalism of Western culture" (Weber 2001: xxxviii). In rejecting the magical and emphasizing the rational, the Protestant ethic succeeded in transferring the cultural framing of life from the supernatural world to the human world. "Ascetic Protestantism had championed the rationalism of world mastery 'in the name of God'; scientific rationalism now propagated it 'in the name of man'" (Roth & Schluchter 1979: 50).

The inner orientation in universalist religions towards a transcendent goal (Schroeder 1987) developed in the Protestant ethic into "a particular transformation of patterns of discipline and methodology" (Turner 1996b: xxii). Weber saw disenchantment of the world increasing as rationalization increases and considered that in the Protestant ethic, and its subsequent transition to secular modernity, this process was radical and decisive for Western civilization (Roth & Schluchter 1979). In science, in particular, the praxis of this problematic correlation is evident. "Sharp and irreconcilable tensions arise between the deeply rooted demand that life and the world possess a coherent overall meaning and the increasingly evident impossibility of determining this meaning scientifically" (Brubaker 1984: 31). This correlation can also be seen reflected in the growing reliance on and expectation of science to provide answers *at the same time* as alternative ideas (e.g., Eastern mysticism, New Age spirituality), rejected by science as irrational, are embraced. The rejection of anything deemed irrational by science has resulted in a "'specifically rational flavor' to the everyday experience of modern individuals" (Brubaker 1984: 31), but the problems of



meaning, as opposed to scientific answers, have arguably increased (Morgan 2002) as scientism has proliferated.

The Protestant ethic also demanded of all a devotion to a vocation, “a calling, which he should profess and in which he should labour” (Weber 2001: 106) in order to determine God’s grace. The belief in predestination demanded a rejection of irrationality (the supernatural) and an assumption of rationality. Weber (2001) identified the Protestant (particularly Calvinist) rational pursuit of salvation in the emphasis on asceticism and hard work in one’s vocation as crucial to the later development of capitalism and secular modernity. With regard to world-views, the Reformation brought about two irreversible developments:

first, the change of a religious ethic of submission into a non-religious ethic of personal autonomy and personal authenticity, and second, the transformation of salvation interests in the direction of success. The tension between divine will and worldly order has been transformed into the tension between human will and social order, and the primacy of transcendence has been replaced by that of this world. (Roth & Schluchter 1979: 52)

The Calvinist world-view fused elements of worldly causality and control and personal integrity into one attitude: “In the name of God you must control yourself and dominate the ‘world’ through your vocation.” (Roth & Schluchter 1979: 42).

The emphasis in the Protestant ethic was for “a life guided by constant thought” (Weber 2001: 72), for “the systematic, methodical character ... demanded by worldly asceticism” (Weber 2001: 107), and for “conscious self-scrutiny” (Brubaker 1984: 25). This religious devaluing of the ‘world’ eventually led to a reversal where the ‘world’ in turn devalues the religious, which Weber saw exemplified in the Western capitalist system (Roth & Schluchter 1979). This Protestant ethic of vocation and its devaluing of the ‘world’ has transmogrified into the modern devotion to career and working in order to determine social wealth, status, and self-value and into the devaluation of the religious. As Protestantism devalued the ‘world’, now science devalues the religious (magical, supernatural) as irrational; as Protestantism valued and elevated vocation on religious grounds, now science values and elevates its professions on scientific grounds. In addition, those working in

professions do so as *part* of the profession itself (Roth & Schluchter 1979) and the bureaucratization and rationalization characteristics of professions (Ritzer 1975) arise from the internal rationalization and duty to vocation of the Protestant ethic. Weber (2001: 124) feared this asceticism, devotion to vocation, and emphasis on rationality would eventually lead to a world inhabited by “specialists without spirit”.

Furthermore, the Protestant ethic of “worldly asceticism” (Weber 2001: 53ff, 107ff) is “anti-emotional” (Brubaker 1984: 25), stemming not only from a rigorous self-control and self-monitoring but also from “the entirely negative attitude ... to all the sensuous and emotional elements in culture and in religion” (Weber 2001: 62). With the waning of the religious basis and imperative, the abhorrence of emotion, *per se*, developed in the modern secular West into abhorrence for ‘particular’ emotions, such as unhappiness, shyness, or anxiety. Where once hedonistic emotions were reviled, now, without the religious impetus, the rationalism, self-control and self-monitoring has remained but the anti-emotional stance has devolved into an anti-‘negative’-emotional stance. This dichotomy between emotions and reason and the equation of health with happiness is problematic (Williams 2000b). Assigning a negative role to certain emotions, largely reducing them to an illness status, results in problems of adequately dealing with suffering and meaning (Morgan 2002). Where once rigorous hard work, worldly economic success and strict self-control were tied together and indicated God’s grace, now worldly success is made up of not only economic success but also of ‘success’ in health, which includes a moral imperative to be happy. Since the Enlightenment there has been a concentration on thinking and reason rather than feeling and emotion, and, in his thesis of the Protestant ethic, Weber draws attention to further significant developments in the history of the West’s association with emotions and rationality and the consequences of these developments.

### **2.3.3 Western Rationalism**

Weber’s discussions concerning rationality are complex, fragmented, incomplete, and variously interpreted (Roth & Schluchter 1979, Schluchter 1981, 1989, Brubaker 1984, Habermas 1984, Lash & Whimster 1987, Whimster 2007). In addition, the

scope of Weber's work about rationality is extensive and complicated, ranging from, for example, his typology of different rationalities<sup>5</sup>, to discussions of the differences between *zweckrational* (ends-means rationality) and *wertrational* (value-means rationality)<sup>6</sup>, to his ideas concerning Western rationalism itself. Nevertheless, the basic thrust of his analysis of occidental rationality provides a powerful conceptual tool for analysing Western culture. The continuing relevance and value of Weber's ideas concerning rationality and Western rationalism are well illustrated by recent research. Examples would include<sup>7</sup>: Habermas's (1984) critical re-working of Weber's thesis of rationality and disenchantment, Ritzer's (1993) examination of society and contemporary rationality using the fast-food industry as exemplar, Cockerham and colleagues' (1993) application of Weberian rationality to health lifestyles, Koch's (1993) exploration of the influence on Weber of the tensions between Enlightenment rationalism and Romanticism's reactive responses to this, and Morgan's (2002) discussions of suffering and meaning. In a similar vein, I consider Weber's concepts of rationality can be effectively used to examine contemporary approaches to other aspects of Western culture, including depression.

While Weber's discussions about rationality provide many possible directions to pursue, I have chosen to focus specifically on Western rationalism and meaning. Although variously interpreted (Lash & Whimster 1987), Western rationalism is generally discussed as an example of Weberian formal rationality (Brubaker 1984), but is also linked to Weberian theoretical rationality because of its focus on scientific concerns with empiricism, evidence, and experimentation (Kalberg 2005). My discussions have tended to be inclusive, reflecting the common understanding of Weber's concept of Western rationalism as shaped by science (Whimster 1987, Morgan 2002), as particularly concerned with causality, certainty, control, predictability, and calculability (Ritzer 1993), and as linking directly to the dominance in the West of the intellectual (scientific) sphere and the emphasis on rationality in the Protestant ethic (Roth & Schluchter 1979, Schluchter 1981).

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<sup>5</sup> Weber's four-fold typology of rationality consists of: practical rationality, concerned with subjective interests; theoretical rationality concerned with cognitive processes; formal rationality concerned with rules and laws; and substantive rationality concerned with values (Kalberg 1980).

<sup>6</sup> Ends-means rationality (*zweckrational*) is concerned with causality and is dominant in Western culture, whereas value-means rationality (*wertrational*) is concerned with comprehensive meaning and is marginalized in importance in Western culture by ends-means rationality (Brubaker 1984).

<sup>7</sup> See also pages 37-38 in this chapter.

Weber (2001: xxxviii) considered that “the specific and peculiar rationalism of Western culture” distinguishes it from all others, not in possessing “intrinsic value” (Whimster 2007: 219) but in the dominant position of formal rationality (Brubaker 1984). The modern Western world is “rational only from a purely *formal* point of view, only in a ... narrowly restricted sense that excludes the evaluative resonance traditionally carried by the word ‘rational’” (Brubaker 1984: 44). Western rationalism is so endemic and so dominant in the West that it has produced a myopic inability to see that the type of scientific rationality it facilitates and privileges is only one type of rationality. It has a limited range of application that should not be, but has been, used beyond its parameters. Weber (1991) recognized the danger in applying scientific rationality beyond its calculable and objective parameters because such rationality can only successfully operate within its narrow confines.

Moreover, science should be operating on the principle of uncertainty, not certainty. Weber was acutely aware of this potential problem, pointing out that, unlike art which “will never be antiquated”, science

will be antiquated.... That is the fate to which science is subjected; it is the very *meaning* of scientific work.... Every scientific ‘fulfilment’ raises new ‘questions’; it *asks* to be ‘surpassed’ and outdated. (Weber 1991: 138)

Based on his views of the transient nature of science, Weber considered the primary task of a teacher to be that of teaching “students to recognize ‘inconvenient’ facts” (Weber 1991: 147). Similarly, the primary task of a sociologist, in my opinion, is to reveal ‘inconvenient voices’, and the ‘inconvenient facts’ they raise, that disrupt “party opinion” (Weber 1999: 147). The dominant ‘party opinions’ in all aspects of contemporary Western life are niggled at by such ‘inconvenient voices’ because they draw attention to the problems of rationality, irrationality, interpretation, and meaning in such dominant paradigms.

In the Weberian conception of rationality, the belief in the West of the value of science to furnish truth is culturally constructed and “not given by nature” (Weber, 1949: 110). It is this that underlies the problems of Western rationalism, and therefore science and its approaches to life and the world: scientific rationality is

deemed *the* rationality against which everything else, to a greater or lesser degree, is consequently deemed to be *irrational*. Indeed, for Weber, rationality is not a given absolute but is always applied to things; it is a “relational concept”: therefore, what is judged rational from one point of view may be judged irrational from another point of view (Brubaker 1984: 35). For Weber (Morgan 2002: 312, quoting Weber), Western rationalism “leads to a profoundly ‘irrational way of life’”. The ‘problem’, then, is not with the scientific, or even sociological, discourses or ‘solutions’, but with Western rationalism itself, in which approaches other than the scientific are judged irrational to varying degrees.

While all rationalities are concerned with mastering reality, Weber considered that only substantive rationality “has the potential to introduce methodical ways of life” (Kalberg 1980: 1164). In particular, ethical substantive rationality<sup>8</sup> produces comprehensive mastery of life by controlling the other types of rationalities through its value base. This can occur in the secular or religious arena. In this way values, and the meanings associated with them, become coherent and comprehensive, ranging across all rationalities and through all the value spheres of life. In the modern West, however, it is scientific rationality, and the subsequent action concerned with ends and means (*zweckrational*), that defines life and holds sway, “the inherent aim of which is the mastery of the world in the service of human interests” (McCarthy in Habermas 1984: xvii).

The scientific world-view undoubtedly provides many benefits through its formal and theoretical rationalities, but fails, according to Weber, to provide meaning for a methodical way of life. Weber considered Western rationalism unable to provide comprehensive meaning for the individual (*e.g.*, Kalberg 1980, 2005, Brubaker 1984, Lash & Whimster 1987, Schroeder 1987, Schluchter 1989, Morgan 2002) as was previously afforded by the ethical substantive rationality of Christianity. This ‘sacred canopy’ is now shattered (Berger 1967) and “no deduction, no reduction and no induction can ever put the canopy of Meaning together again” (Zijderveld 1986). Weber believed that the domination of substantive rationality by Western formal rationality has negatively impacted on individuals by limiting understanding of the

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<sup>8</sup> Religions are classic examples of ethical substantive rationality. In the West, Christianity functioned as an ethical substantive rationality that only began waning with the Enlightenment.

world to scientific parameters over a methodical approach to life (as provided by ethical substantive rationality).

Weber saw meaning “as the essential property of human action ... [and] intrinsically linked with rationality” (Brubaker 1984: 92) and, because of the distinctive nature of Western rationalism, he was gravely concerned about the possibilities for meaning in the modern West. While recognizing the value of reason and science, Weber “directly challenged ... the Enlightenment faith in reason and progress in ways that remain relevant for us today” (McCarthy in Habermas 1984: xvii). He was deeply worried “[t]hat the fate of our times is characterized by rationalization and intellectualisation and, above all, by the ‘disenchantment of the world’” (Weber 1991: 155). Thus, although Weber “renews the Enlightenment ideal ... for our time, [he] ... also breaks with the idea of a life based on reason alone”, because human beings “find out that conscious life cannot be lived merely through reason” (Schluchter 1989: 276, referring to Henrich). From the Weberian perspective, rationalization is seen as “a set of interrelated social processes by which the modern world has been systematically transformed” (Turner 1996b: xix).

Weber also saw the modern West as having problems with meaning because different rationalities “may mean many different things” (Habermas 1984: 168) and the “new polytheism” has resulted in “loss of meaning” (Habermas 1984: 247). In the modern West, there is no longer an ethical substantive rationality that orders a whole-life response to reality in a methodical way. Western rationalism, based primarily on formal rationality and the intellectual sphere, views substantive rationality as irrational, pushing it to social liminality; and practical and theoretical rationality, concerned with individual self-interests and abstract matters, respectively, also deem substantive rationality irrational and unnecessary (Brubaker 1984, Schluchter 1989, Morgan 2002). Without an ethical substantive underpinning, the different rationalities in the different value spheres pursue their own ends as disparate entities, devoid of the values previously provided by substantive rationality. Consequently, according to Weber “we are trapped between the epistemological demands of enlightenment rationalism and the ontological pressure for a complete human existence” (Koch 1993: 143).

Weber was acutely pessimistic and the issues and ideas he presented “are without exception related to his growing anxiety about the future of the liberal societies of the west” (Mommsen 1974: 1). His “anxieties and uncertainties about the moral (and indeed spiritual) significance of modernity have been reproduced in our uncertainties about what sort of ‘reality’ might lie beyond modernity” (Turner, in Weber 1991: xxviii). Weber considered that in “no sphere of life ... has rationalization unambiguously advanced human well-being” (Brubaker 1984: 3). He was deeply concerned about where the dominance of Western rationalism had led to and would further lead: to “a polar night of icy darkness and hardness” (Weber 1991: 128) he despaired at the end of ‘Politics as a Vocation’; or to an “iron cage” (Weber 2001: 123) he despaired at the close of *The Protestant Ethic*; or to disenchantment, the “fate of our times”, and the pointlessness of yearning for scientific answers he despaired at the end of ‘Science as a Vocation’ (Weber 1991: 255 ff). Habermas (1984: 247) observes that Weber interpreted the loss of meaning he had identified as “an existential challenge to the individual to establish the unity which can no longer be established ... with the courage of despair, the absurd hope of one who is beyond all hope”. Mommsen (1974: 112), then, quite aptly described Weber as “a Liberal in despair”. Yet, as Turner (Weber 1991: xxviii) observes, although Weber was “clear in his mind ... [that] the world beyond modernity promised to be especially terrible”, perhaps his “profound probing of the edges of that dark world [that icy night of polar darkness] is one reason why Weber’s sociology continues to fascinate each new generation of scholars”.

Nevertheless, although Weber is often reasonably interpreted as very gloomy about the effects of Western rationalism this does not entirely constitute the Weberian position. More recently, scholars (e.g., Seidman 1984, Alexander 1987, Kalberg 2005) have criticized the assessment of Weber as entirely pessimistic, pointing out that he also considered there to be benefits as well as disadvantages to Western rationalism, and that his view of history “was pragmatic rather than pessimistic” (Roth & Schluchter 1979: 205). They emphasize that Weber was optimistic that Western society, because it no longer controlled the individual through an overarching meta-narrative, afforded personal freedoms of choice for individuals. This freedom to choose is a significant contribution of Western rationalism to Western culture. Thus, Weber, while critical of the disadvantages of Western rationalism in

terms of the loss of meaning, also considered the personal freedom it afforded to be an advantage (*e.g.*, Seidman 1984, Kalberg 2005). However, from a Weberian perspective (Weber 1991), these advantages are confined *within* its ‘specific and peculiar’ bounds (the scientific / intellectual sphere of formal rationality). While Weber considered the value spheres to be “irreconcilable” (Weber 1991: 152), emphasizing that individuals must choose between them, this does not prevent the recognition that there are different values afforded by these different spheres. However, for Weber (1991: 143, quoting Tolstoy) “science gives ‘no’ answer” about “what ... [to] do and how ... [to] live”. This is a significant aspect of Western rationalism because it complicates all discussions between science and other fields.

Weber’s thesis of Western rationalism can be seen to be *both* applauding its advantages and the freedom of people to choose as well as bleakly mourning the loss of substantive rationality, particularly ethical substantive rationality. Thus, while secular modernity has destroyed the

traditional cosmological framework of order and meaning, it does not entail the end of meaning. Weber’s position is that the conditions and nature of meaning in modernity are transformed, not extinguished. (Seidman 1984: 398)

Moreover, Mommsen (1987: 50) views Weber’s “gloomy prognostications on the future petrification of the Western world” not as “statements about the finite nature of history, but rather as prophetic warnings designed to call forth forces to counter” the potential dangers of Western rationalism.

Western rationalism, in curtailing meaning to scientific cause and effect, has made meaning of a comprehensive, transcendent type impossible to achieve. It has replaced comprehensive regulation of life not only with individual freedom to choose but also with the necessity that individuals *must* choose between competing possibilities. The effects for society and the individual of the replacement of religion with science as *the* world-view and its concomitant contestation with other world-views (*e.g.*, religious, New Age, philosophical, sociological) is arguably more pronounced than it was in Weber’s day. Weber’s prognosis of the ‘warring gods’ “has come to be much more accurate than Max Weber himself had assumed in his



lifetime” (Mommson 1974: 115). Nevertheless, modernization for Weber is a two-sided process and what “we lose in moral certitude, we gain in personal freedom and responsibility” (Seidman 1984: 399). Weber’s thesis of Western rationalism provides an extraordinary wealth of material to draw on when examining contemporary Western culture.

## **2.4 Derrida and Levinas**

Interest in ethics, difference, and interpretation are central to the work of Derrida and Levinas, although their approaches show differing developments (Critchley 1992, May 1997, Abbinnett 2003). Indeed, May (1997: 1-2) discerns a pattern in the work and focus of recent French philosophers, including Levinas and Derrida, concerned by what they see as an overriding problem with “the articulation of an adequate concept of difference, and as well a proper sense of how to valorize it”. It is this concern with difference, interpretation, and respect that I have found valuable to draw on in the construction of my theoretical model. In particular, I have utilized Derrida’s ideas concerning the Western preoccupation with logocentrism and the two types of interpretation and Levinas’s concepts of Other and Same in order to enrich from other perspectives the characteristics of secular Western modernity that Weber saw as having both advantages and disadvantages for the West

### **2.4.1 Derrida**

There are ... two interpretations of interpretation; ... The one seeks to decipher, dreams of deciphering a truth or an origin which escapes play.... The other, which is no longer turned toward the origin, affirms play. (Derrida 1978: 292)

Derrida is considered virtually synonymous with post-structuralism and “is perhaps best known for inaugurating ‘deconstruction’” (Rice & Waugh 1996: 173). Although originally part of philosophical, literary, and linguistic critical theory (Culler 1982),

Derrida's concepts have increasingly been more widely considered (Critchley 1992, Abbinnett 2003, Reynolds & Roffe 2004, Wood 2005). As with Weber, the work of Derrida is a rich and rewarding source for research and application (Wood & Bernasconi 1988, Boyne 1990, Trifonas & Peters 2005, Glendinning & Eaglestone 2008) as well as critique and extension (Wood 1992, May 1997, Kearney 1999).

While not wishing to pursue complex discussions concerning language, metaphysics and meaning, Derrida's ideas, nevertheless, furnish useful concepts in furthering an understanding of Western cultural development. In particular, Derrida's challenge to the logocentric tendency in Western thought, in which he introduces his concept of the two interpretations of interpretation, is valuable for my study of depression. One of these interpretative positions Derrida calls the Rousseauistic Interpretation because it seeks the centre, seeks an absolute interpretation and final meaning. Derrida considered the Rousseauistic Interpretation "very much at work in the modern sciences" of the West and particularly in "thinking about language, society and cultural history" (Norris 1987: 127-128). The other interpretative position Derrida calls the Nietzschean Interpretation because it affirms freeplay and the plurality of interpretation and meaning. Deconstruction is the Nietzschean Interpretation in practice, concerned with what is hidden in the margins of the text (Silverman 1989) and is also "a mode of self-knowledge" (Bradbury 1985: 7). However, deconstruction "is not synonymous with destruction" (Salusinszky 1987: 164, quoting Johnson), and is very much an ethical endeavour, informed by Levinasian ethics (Critchley 1992). Indeed, Derrida insists on "a scrupulous use of deconstruction" (Kearney 1999: 177), emphasizing that it is to be viewed as an "affirmation" (Salusinszky 1987: 9) and that discussion "'ought to be at bottom an ethical-political one'" safeguarding "'an openness toward the other'" (Kearney 1999: 176, 164, quoting Derrida).

While Derrida (1978: 293) clearly prefers the Nietzschean Interpretation to the Rousseauistic Interpretation, he does not suggest choice; rather, he calls for the conception of "the common ground" where these two opposites can coexist. However, it is not a common ground where similarity exists but one where the differences must be noted and highlighted. As Weber considers the different value spheres and rationalities irreconcilable, so Derrida considers the two interpretations

absolutely irreducible and irreconcilable. Yet, Derrida (1978: 293) insists that even while living “them simultaneously ... the *différance* of this irreducible difference”<sup>9</sup> must be conceived. It is this emphasis on both the irreducible and irreconcilable nature of difference and the common ground of *différance* that provides a fascinating possibility of living ‘with’, rather than ‘against’, that which is different.

These two interpretative positions originate from Derrida’s critical view of Western thought as caught up in attempts to determine fundamental principles by fixing centres into every structure. Logocentrism ensures self-referential stability by “orienting and organizing the coherence of the system”, thereby limiting “the *play* of the structure” (Derrida 1978: 278-279). The centre has historically received different names in Western thought and “must be thought of as a series of substitutions of center for center” (Derrida 1978: 279). As each new thought system became established a new centre replaced the old centre. While the organizing principle, the centred interpretation, remains the same, the type of centre varies. Christianity and Western science are both examples of this centred or Rousseauistic Interpretation, where both are defined by the centring of a belief system on a single centre, to the exclusion of other centres, by which it is then self-validated and from which it attributes meaning. Meaning holds true within the structure by virtue of the centre, but compared to another structure controlled by a different centre such meaning becomes problematic. Derrida’s critique of logocentrism “‘is above all the *search for the other*,’ an attempt to ‘reevaluate the indispensable notion of responsibility’” (Kearney 1999: 164, quoting Derrida). For Derrida, the logocentric tendency has been shattered in the modern West and now the centred interpretation is continually disrupted by plurality of interpretation and meaning, just as Weber saw the modern secular West comprising both the perspectives of a total world-view and pluralism.

While in the Rousseauistic Interpretation meaning is grounded, in the Nietzschean Interpretation meaning is ungrounded. However, accepting the decentred position of the Nietzschean Interpretation does not mean that the logocentric concepts of the

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<sup>9</sup> In the neologism *différance* Derrida (1978: xvi) combines both “to differ (in space) and to defer (to put off in time)”, representing “the systematic play of differences, of the traces of differences, of the *spacing* by means of which elements are related to each other” (Derrida 1972: 27). In using ‘a’ instead of ‘e’ in *différance*, to distinguish it from ‘difference’, results (in French) in the erasure of the ‘e’ because the ‘a’ is silent; hence this distinguishing mark “‘remains silent, secret, and discreet, like a tomb’” (Ormiston 1988: 42, quoting Derrida).

Rousseauistic Interpretation cannot exist, but that they cannot be proved to exist and should therefore not be termed final or absolute. According to Derrida, the centre both facilitates the restricted ‘play’ of elements within the structure but also closes off other ‘play’: “At the center, the permutation or the transformation of elements ... is forbidden” (Derrida 1978: 279). One logocentric view of the world, as with one Weberian total world-view, does not allow for another logocentric interpretation at the same time. Derrida, however, does acknowledge the human need to assign meaning and that the security of belief afforded by logocentric thought systems is understandable as through them “anxiety can be mastered” (Derrida 1978: 279). Derrida, nevertheless, warns against the “Enlightenment cult of a single idea” because simplifying or complicating discussion is, finally, a refusal “to respond to that dimension of otherness” (Kearney 1999: 176).

These Derridean concepts of logocentrism and interpretative positions reveal in a different way the ideas of Weber concerned with a total world-view and the domination of the Western rationalist viewpoint over other rationalities. Both Derrida and Weber are interested in explicating how interpretations of the world are determined by particular perspectives. The Derridean Rousseauistic Interpretation, with its need to centre, parallels the concern in Weberian Western rationalism with ultimate truth, predictability, and control. In addition, both the Derridean and Weberian conceptual positions draw attention to the existence of plurality and the fact that there are different paradigms from which to see and understand the world. These paradigms, because they are self-referential, consider other paradigms, other rationalities or centres, to be irrational and devoid of ‘true’ meaning. Weber saw the different rationalities as disparate and the different value spheres as “unbridgeable” (Weber 1991: 154) while Derrida saw the two interpretations as oppositional.

The positions of both Derrida and Weber are to a degree characterized by recognition of loss. Derrida saw the Rousseauistic Interpretation as “the saddened, *negative*” interpretation of “an exile” (Derrida 1978: 292). This parallels the Weberian idea (Weber 1991: 155) that progressive rationalization resulted in progressive “disenchantment of the world”, culminating in the West in the Protestant ethic, which ultimately contributed to the formation of Western rationalism in secular modernity. For Weber, “modernity, before it is anything else, is a condition of loss”

(Faubion 1988: 366). Derrida's (1978: 293) 'solution' was seeking "the common ground" of the two interpretations and "the *différance* of [their] irreducible difference" which he conceived of as "the as yet unnamable ... infant". Weber's (1991) 'solution' was to muster the integrity to "bear the fate of the times" (155) and choose between the "warring gods" (153), and even though he also "argued that scientific rationality and ethical values should coexist ... [he] did not identify the conditions under which such a coexistence might be achieved" (Alexander 1987: 204). In a sense, both solutions could be seen as problematic: while both theorists emphasize ethical responsibility (Critchley 1992, Turner 1996b), they both describe positions strongly characterized by a tension between irreconcilability and hope. In constructing my theoretical framework, I have noted these 'problematics', and, following scholars such as, for example, Habermas (1984) or Alexander (1987) on Weber and May (1997) or Kearney (1999) on Derrida, I have attempted to also 'see' a little further.

## 2.4.2 Levinas

[W]hat would it mean if, rather than responding to the threat of the Other with violence, we endeavoured to accept our dispossession of the world, to listen to the voice of the Other rather than to suppress it? (Davis 1996: 144)

The philosophy of Levinas represents a particular focus on ethics and meaning in the West, and its importance derives from "the crucial role it accords to the problem of otherness" (Davis 1996: 3). Highly respected in European philosophy, Levinas has influenced fields ranging from philosophy and theology to sociology and critical theory. His ideas continue to attract attention, leading to far-ranging discussion and debate (*e.g.*, Critchley 1992, Davis 1996, Peperzak 1997, Kearney 1999, Abbinnett 2003) and critique and re-appraisal (May 1997, Shildrick 2002, Wood 2005). Of particular value for my study are the Levinasian concepts of Same and Other, the impulse in the West of reducing Other to Same, and the need for respectful encounters with Other.

The Levinasian concepts of Same and Other provide a useful theoretical perspective from which to examine secular modernity. Same has always been the “privileged term ... which is conceived as incorporating ... that which lies outside it” (Davis 1996: 40). Because Same represents certainty, knowability and security for the self, an encounter with the Other always destabilizes and always demands a response. The relation of self to Other is highly complex, involving both “the separation and inseparability of the Other” to self, a relationship “characterized by a radical *asymmetry*”<sup>10</sup> (Peperzak 1997: 207-208). The relational nature of the relationship between Same and Other is central to Levinasian ethics. Indeed, for Levinas “ethics is simply and entirely the event of this relation” (Critchley 1992: 5). Levinas sees relations with, and responses to, the Other “as that which founds the self as a subject, that instantiates its very being” (Shildrick 2002: 88). Same refers not only to the “intentional acts” of the ego but also to the “intentional objects which give meaning to those acts” (Critchley 1992: 4). For Levinas the alterity of Other can never be reduced to Same and is always transcendent, and “touches us by leaving traces which challenge and resist comprehension” (Peperzak 1997: 106-107).

Levinas is critical of attempts, evident throughout Western philosophy, of changing Other into Same (Davis 1996). These attempts result in a kind of “digestive philosophy” that suppresses or reduces “all forms of otherness by transmuting their alterity into the Same” (Critchley 1992: 6). Due to the privileging of Same, there is a strong tendency in Western thought to acknowledge the Other only in order to suppress or possess it (Davis 1996). This states in a different way the ideas of Derrida on logocentrism and Weber on the impulse in the total world-view to master the world. Situating the ethical relationship prior to “the logical hierarchies of social ontology” (Abbinnett 2003: 16) is a radical reversal of the Western convention in which ethics is viewed as a “subset only” (Shildrick 2002: 87), and represents Levinas’s intent to award ethics status over the West’s “scientifically oriented culture” (May 1997: 161). Other, then, is doubly problematic for Same: Same is “called into question” by that (the Other) which “cannot be reduced” to itself (Critchley 1992: 5). This succinctly represents both the secular-scientific emphasis

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<sup>10</sup> I am aware that the asymmetrical relationship between Other and Same raises questions regarding the ethical nature of such a relationship. However, for the purposes of my theoretical framework, my interest is in utilizing Levinas’s insistence on respect in the relationship with Other.

on mastery and control and its inability to cope with any loss (present or future) of that mastery and control.

In his ethics, Levinas seeks to provide a philosophy that facilitates a respect for encounters with the Other. Levinas uses the word Enigma to describe the essential mystery of the Other: it “withdraws”, it “is not a mystery to be explained, but an essential secret which cannot be fully revealed” (Davis 1996: 90). Such an approach is antithetical to the secular / scientific approach to the world, with its emphasis on seeking answers, knowing, explaining, and thereby controlling. This ethical demand is the “organizing theme” of Levinas’s work and his philosophy is “a provocation, a demand, above all, to specify the fate of the ethical relation within the socio-economic and technological development of modernity” (Abbinnett 2003: 16, 23). Levinasian philosophy “disrupts ontology and logocentrism” (Critchley 1992: 9) and seeks to develop a way of relating to Other. Levinas sees the face-to-face encounter with the Other “as originally pacific” (Davis 1996: 48), but that puts the individual “into question by revealing to me that my powers and freedom are limited” (Davis 1996: 49).

This encounter between the self and the Other is seen by Levinas as ethical; but how the individual responds to this encounter may or may not be ethical as it can be either one of violence or one of respect. The former is most often the response to the face of the Other and arises in an attempt to reduce or eradicate the challenge to the self that the Other instigates. The latter response (respect) stands in complete contradiction to the impetus in Western science and secular modernity that seeks to fully explain, and thereby fully control. Respect for Other, as it manifests in encounters between self and Other, is fundamental to Levinas’s ethics. Other can have many faces, and self can encounter Other in the form of other people, other beliefs, other opinions, other cultures, other world-views, or whatever is ‘other’ – even illness itself. Levinas endeavours “to protect the Other from the aggressions of the Same, to analyse the possibilities and conditions of its appearance in our lives, and to formulate the ethical significance of the encounter with it” (Davis 1996: 3). The ethics of Levinas provide a valuable perspective that is complementary to the ideas of both Weber and Derrida.

## 2.5 Conclusion

In this chapter, I explore the theoretical concepts out of which I construct the theory used in my thesis. From the wealth of potentially valuable theoretical possibilities that I pursued, I chose to use the ideas of Weber, primarily, but also those of Derrida and Levinas, as all are concerned with an historical-cultural perspective of life and living in the world. Weberian concepts concerning secular modernity, augmented by Derridean and Levinasian ideas, provide rich possibilities from which to create a theoretical foundation to explore the framing of depression in contemporary Western culture.

The past defines the present in many, often unseen, ways and I believe that the concepts of these three theorists facilitate the situating of discussions about depression within its constitutive historical-cultural framing. The reason for this is that their ideas specifically furnish and encourage exploration about how humans see, engage with, and interpret the world and hence assign meaning. In addition, they all share concerns about the importance of respect and about how humans meet the ‘other’. In application to my topic of depression this constitutes, I suggest, a fundamentally different way of studying how the contemporary West views depression. In taking this approach, I hope to contribute to and encourage broader discussion and debate about depression and to further expand the use and value of the ideas of Weber, Derrida, and Levinas in studies of contemporary culture.

The impact of Derrida’s work has been described as “akin to ‘something that goes bump in the day’” (Glendinning & Eaglestone 2008: xi, quoting Royle). Paraphrasing and extending this analogy, I suggest that the impact of Weber’s work is akin to ‘something seeking the interconnectedness of what went bump, and why and how it went bump’, and the impact of the work of Levinas is akin to ‘something that respects whatever went bump and urges that it not be reduced to Same’. Taken together, the impact of their work on me has resulted in the creation of a theoretical framework I have termed the ‘Quatrefoil Model of Historical-Cultural Framing’ (see Chapter Four). I envisage that this theoretical model, in application to my chosen



topic, will gently startle and unsettle, challenge and stimulate, advocate open exploration and interpretation, and firmly urge respect.

All theories and theoretical models, however, are only ever interpretative positions; moreover, they are made from surrounding theories and ideas and are formed from interactions between them. Indeed, although a ‘rationalist construction’ by which to study depression, my theoretical model, because it has arisen from what could be described as a Deleuzian “interference of many practices” (Colebrook 2002: xliv) and a Gadamerian “fusion of horizons” (Dallmayr & McCarthy 1977: 288), is particularly characterized by interrelatedness and openness. I see my research as an example, in a very small way, of answering Weber’s “call” for “forces to counter” the negative aspects of Western rationalism (Mommsen 1987: 50). At the same time, following Weber’s affirmative attitude towards the advantages of Enlightenment reason (Schluchter 1989), my research also values the positive aspects of Western rationalism. Before introducing my theoretical model (see Chapter Four), I will first briefly discuss Western responses and approaches to suffering against which I then broadly situate my discussions in Part Two.

## Chapter Three

# Background: Motifs of Suffering in Western Culture

**The more things change, the more they are the same.**

(Alphonse Karr)<sup>1</sup>

**[T]he horizon of the present is constantly being developed ... [by] the encounter with the past and the understanding of the tradition out of which we have come. Thus the horizon of the present is not formed without the past. There is no more a separate horizon of the present than there are historical horizons that have to be acquired. Rather, understanding is always the process of fusing such supposedly self-sufficient horizons.**

(Hans-Georg Gadamer)<sup>2</sup>

**About suffering they were never wrong,  
The Old Masters: how well they understood  
Its human position.**

(W. H. Auden)<sup>3</sup>

### 3.1 Introduction

In this chapter, I paint a background about suffering against which I render my study of depression. In a sense, this background is largely translucent, in that its presence, while not invisible, is easily overlooked as crucial in influencing how we view depression today. Given that depression is a form of suffering and that the contemporary framing of depression is not isolated historically or culturally, an exploration of how the West has approached suffering provides useful and valuable

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<sup>1</sup> Knowles 2004: 441

<sup>2</sup> Habermas 1977: 343

<sup>3</sup> Auden 1979: 79

information and perspectives that function to illuminate aspects of our understandings of depression.

Through an examination of religious, ancient Greek, and modern secular-atheistic literature, I demonstrate that the Western response to suffering, spanning some four thousand years, is characterized by an extraordinary longevity of thematic tensions. These oscillate like sound waves, sometimes spiking, sometimes dipping, but always vibrating. Tensions between a recognition and acceptance of the existence and value of suffering and a desire to control and prevent suffering emerge as consistent features of these responses. From these enduring tensions that connect various conflicting, but related, themes along continuums between opposing polarities I devise four ‘motifs of suffering’ that distil the responses to suffering I discerned in the literature: ‘acceptance and resistance’, ‘relationship and causality’, ‘chaos and certainty’, and ‘descent and ascent’.

Using a rationale for the selection of literature based on criteria of clearly engaging, whether directly or by implication, with suffering and the human condition inevitably resulted in a vast array of choices. Numerous texts would admirably serve such criteria. However, to be broadly representative of Western culture across time I chose examples from antiquity and the present, and to be broadly representative of Western culture across different world-views I chose both secular and religious material. The resulting selections of *Job* and ancient Greek literature from the past and secular-atheistic literature and Christian hymns and songs from the present provide a wide-ranging, though partial, sweep of literature revealing the continuing Western engagement with suffering.

The value of such a meta-approach to Western responses to suffering is three-fold: it gives a broad perspective on how suffering has been viewed both in the past and today, demonstrates continuities over time, and enables contemporary approaches to depression to be situated within the historical context of long-standing Western approaches to suffering. Necessarily incomplete in a study of this size such an investigation, nevertheless, furnishes in broad brush strokes a literary historical-cultural background to this study.

This background facilitates a different perspective on how depression is currently approached, medically or sociologically. By relating the Motifs of Suffering to current understandings of depression, aspects characterizing the long-standing Western approach to suffering can be seen reflected in aspects characterizing the contemporary Western framing of depression. For example, the focus on resistance to suffering is reflected in the emphasis on defining and diagnosing depression and ascertaining efficacious treatment options (Ebmeier *et al* 2006) and in the emphasis on the link between depression and gender (Bracke 2000). The focus on the causality of suffering is reflected in the emphasis on scientifically analysing the causes of depression (Keller 2003) and in the emphasis on explicating the social causes of depression such as poverty (Meertens *et al.* 2003). The focus on certainty as a means of establishing the correct approach to suffering is reflected in the certainty of the medical profession concerning its scientific perspective on depression as an illness that can be treated (Mann 2005) and in the emphasis in sociology on the problems of medicalization and the rejection of alternative healing systems (Freund & McGuire 1995). The focus on ascent from suffering is reflected in the overall approaches to depression evident in material produced for the public to educate them about depression as an illness that can be effectively treated (*beyondblue*, the Australian website on depression) and in the overall sociological approaches to depression concerned with isolating social factors impeding diagnosis or treatment (Brownhill *et al.* 2005) and with improving delivery of current medical treatments (Malpass *et al.* 2009). While the Motifs of Suffering are only broad categories by which to understand suffering they provide a foundational basis that helps elucidate the contemporary Western framing of depression in all its complexity and ambiguity.

### **3.1.1 Introducing the Selected Literature**

The old folklore tale of the suffering Job was an oral story probably dating from four thousand years ago and was circulating in the second millennium before the Common Era (BCE). Canonical to both Judaism and Christianity, the Book of *Job* is an ancient literary masterpiece about suffering, as puzzling, provocative, and challenging today as when it was first written down over two and a half to three thousand years ago, with additions added probably in the sixth century BCE. *Job* is a

story replete with tension and dichotomy in the devastation of suffering experienced by Job, the unhelpfulness of his ‘friends’ (or ‘comforters’ or ‘advisers’), who are anything but friends, and the enigmatic presence of God. In this chapter, I examine a liberal Judaic-Christian reading of *Job* (the NRSV edition of the Bible is used: May & Metzger 1977) to tease out these tensions. While clearly arising from Hebraic religious and spiritual history, *Job* is a problematic and difficult book and stands apart for what it says about suffering and God. As Job points out (*Job* 21), God is not behaving as he ought according to Hebrew belief. In many ways, the Job story is a precursor of the Jesus story, as both are concerned with suffering and communion with God.

The second area of material I examine is Nussbaum’s (1986) account of ancient Greek tragedy and the responses to it by Plato and Aristotle (sixth to the fourth centuries BCE). I have drawn heavily on her argument that Greek tragedy provides valuable insights into how people in Ancient Greece sought to control their social world in order to achieve a good life and that such insights have value for us today. Ancient Greek thought recognized the vulnerability of human beings to the vagaries of luck (*tuché*) and that a ‘good life’ (*eudaimonia*) could be thwarted or ruined by external factors beyond their control. This problem of the vulnerability of human life led, on the one hand, to a hope that human rationality (in the form of science) might help control, if not eradicate, this *tuché* and the suffering it wrought. On the other hand, in tension with this strand of thought, was a tangent that saw in tragedy a profound understanding of the place of suffering in human life, that saw the vulnerability of the human to pain as a part of what it means to be human, and that recognized that part of the beauty of humanness is vulnerability to suffering.

Both Plato and Aristotle continue the concern of the tragic poets in dealing with the place of luck, suffering, and what is beautiful and valuable in the human, but they pursue very different approaches. Nussbaum (1986) examines Plato’s emphasis on the rule of reason alone and the role of the expert to control the human susceptibility to pain and Aristotle’s emphasis on the complexity of human life and the relationship between vulnerability to pain and what is good and valuable in the human being. Where Plato sought, emphasized, and promoted an exclusive and scientific solution to the problem of suffering, Aristotle both defended and emphasized the point of

view of the tragic poets that the beauty and goodness of the ‘good human life’ was inseparable from tragedy and suffering.

For the third area of literature, I selected three classics of modern twentieth century secular-atheistic literature: Camus’s *The Plague* (1960), a story about the responses of people in a town struggling to cope with an outbreak of deadly plague; Solzhenitsyn’s *One Day in the Life of Ivan Denisovich* (1963), a story drawn from his own experiences of struggling to survive in a Soviet labour camp; and Frankl’s *Man’s Search for Meaning* (2004), a reflective autobiographical account of struggling for survival in Nazi concentration camps. These selections explore responses to suffering in extreme situations and contain, I suggest, a concentrated distillation of Western responses to suffering evident in *Job* and ancient Greek thought. These three texts all say similar things about suffering and the human condition. For example, the emphasis on luck, responsibility, and suffering as a part of the human condition echo the concerns and attitudes of the ancient Greeks, while the emphasis on the inability to understand the world and the need for faith in God despite suffering, as represented in the characters of Alyosha and Paneloux, echo the position of *Job*. In all these works is an exploration of the possibility of enlightening and ennobling responses to life despite extreme suffering and the attainment of meaning within that suffering.

Finally, in my textual analysis of Christian music I focus on the language used in twenty-five hymns found in two collections by The Australian Hymn Book Pty. Ltd., *The Australian Hymn Book* (AHB 1977) and *Together in Song: Australian Hymn Book II* (TIS 2006) and in twenty-five songs from the Sydney-based Hillsong Church (Hillsong 1999, 2001, 2002, 2004a, 2004b, 2005, 2008) as a way of exploring the differing responses to suffering that are to be found within contemporary Christianity. This literature, as with the modern secular-atheistic literature, demonstrates a continuation of responses found in *Job* and in ancient Greek thought.

The hymn collections result from ecumenical collaboration between mainstream churches and are drawn from many centuries of Christian worship and from different cultures. In contrast, the songs from Hillsong, an evangelical Pentecostal church, are exclusively contemporary. They are widely available on CD’s and DVD’s, in

numerous music books, as ‘ring-tones’ for phones, and on the web, and some singers / composers enjoy celebrity status. The music of this mega-church has provided an extraordinarily successful marketing strategy for the proliferation of its brand of Christianity and its lucrative music industry (McIntyre 2007). However, whereas a wide variety of indexes to access the hymns in *AHB* (1977) and *TIS* (2006) provide a miniature of life in hymns (marriage, death, courage, adversity, joy, love, justice, liberty, trust, healing, unity, suffering, fear, anxiety, and doubt, *et cetera*), for Hillsong songs no indexes are available to assist in the selection of songs suitable for different occasions or needs. Indeed, Hillsong songs seem to cater for only celebration, joy, and love. The hymns tend to exhibit a greater variety of Christian responses to suffering than the Hillsong songs. The latter exhibit a particular Christian vision of human life that barely acknowledges the place of suffering; and, as such, represent a good example of engagement with suffering through textual *in absentia*, where some responses are invoked by their absence and through over-emphasis on opposite responses.

### **3.1.2 Introducing the Motifs of Suffering**

Analysis of themes I discerned in the selected literature reveals consistent concerns for explaining and controlling suffering, on the one hand, and for accepting and valuing suffering, on the other hand. A central focus is to attribute meaning to suffering. The responses reveal a remarkably similar range of possibilities in approaches to suffering, although the emphasis and expression of these possibilities could vary, whether in religious or non-religious literature or in ancient or contemporary literature. In addition, also significant is that these responses either directly raised or indirectly implied the same tensions.

From these tensions, that so clearly connect the various opposing themes, I constructed four motifs that encapsulate the concerns in the literature: in the ‘acceptance and resistance’ motif are reflected oppositional concerns with openness or control; in the ‘relationship and causality’ motif can be seen diametrically opposed responses of interconnectedness or solution; in the ‘chaos and certainty’ motif are reflected responses of paradox versus clarity; and in the ‘descent and ascent’ motif

are evident opposing journeys of engagement with or movement away from suffering.

The place of suffering in the human story and why suffering happens, even to ‘good’ people, are perennial issues. Suffering is enormously complex, and perhaps extends far beyond the ability of any framework to adequately address in terms of understanding and meaning. Indeed, maybe suffering is beyond any type of rational analysis. Nevertheless, in the West, constructed frameworks constitute a favoured way of attempting to understand the world. While these four motifs represent useful categories for exploring how suffering has been and is approached in the West, such delineated categories provide merely one tool by which to attempt such understanding and do not, and cannot, deliver a definitive and comprehensive exposé of the Western approach to suffering. Moreover, these motifs are ‘ways of seeing’ the problem of suffering, not ‘solutions’ to the problem of suffering.

### **3.2 Acceptance and Resistance**

The West has consistently struggled to make sense of suffering along a continuum between acceptance and resistance. On the one hand, acceptance of suffering involves some sort of openness to life as it is, as opposed to how it may be wanted. It is an embracing of life in all its vicissitudes and complexities. Such acceptance, however, is not resignation characterized by fatalism and powerlessness; rather, it is active engagement characterized by receptivity and responsibility. Nevertheless, as an extreme, acceptance of suffering can be a dangerous and debilitating resignation. Resistance to suffering, on the other hand, involves some sort of repudiation, rejection, or re-casting. It requires a type of acceptance conditional on clearly defined control; where, for example, bad behaviour results in suffering and good behaviour in avoidance of suffering. Though it may not be possible to completely reject or ignore suffering, if it can be controlled then it can be mastered and resisted. In its extreme form, resistance to suffering can be an insidious denial of the existence of suffering altogether. The thematic tension between acceptance and resistance of suffering pivots on avoidance: to not avoid or to avoid, and by how much.



Perhaps nowhere in all of Western culture has the tension between acceptance of suffering and resistance to suffering been more fully, explicitly, and beautifully manifest than it was in the ancient Greek exploration of tragedy. The scope, depth, and value of this engagement is recognized by contemporary thinkers as diverse as Nussbaum (1986) and Tracy (Coffey 2005), and before them Weil and Nietzsche. Greek tragedy, in positioning suffering within the parameters of what defines the human and as part of, related to, and expressive of a person's goodness and value, presents human life as both 'tragic' and beautiful. The Greek tragedies

offer no solution in bewildering tragic situations – except the solution that consists in being faithful to or harmonious with one's sense of worth by acknowledging the tension and disharmony. (Nussbaum 1986: 81-82)

The human condition is vulnerable to *tuché* (luck) because it is fragile. While human beings may want to reduce the risk of adversity in their lives by trying to reduce the tragic consequences of *tuché* they also risk diminishing other aspects of luck and of themselves, and, hence, of their humanness.

On the one hand, reason can be used to control luck and reduce or prevent suffering, but on the other hand the tragic poets recognized that "part of the peculiar beauty of human excellence just is its vulnerability" to suffering (Nussbaum 1986: 2). For example, Sophocles's *Antigone* warns that, while pain raises the possibility of its elimination by trying to close off risk and control the tragic, when human life ceases to be vulnerable to pain its connection to both the tragic and the beautiful is lost. Both Antigone and Creon resist suffering by their inflexibility in dealing with life's problems. They display "a ruthless simplification of the world of value which effectively eliminates conflicting obligations" (Nussbaum 1986: 63), but which both creates and resists the 'tragic view'. The key, as Nussbaum (1986) reads the *Antigone*, is flexibility in response to the world, rather than rigidity.

Conversely, Plato emphasizes resistance to suffering by presenting a "radical, stern, and beautiful proposal for a self-sufficient human life" (Nussbaum 1986: 87). The best human life, one that is "ruled" by reason, is that of the philosopher: "pure, hard, single, unchanging, unchangeable. A life, then, of goodness without fragility"

(Nussbaum 1986: 138). Only through science and the expert can ordinary human lives be saved from needless tragedy and suffering. Science is seen not only as necessary but also as able to provide the correct way of seeing the world and resisting suffering. According to Plato, science is able to change the world, and if “part of our humanness is our susceptibility to certain sorts of pain, then the task of curing pain may involve putting an end to humanness” (Nussbaum 1986: 120).

Aristotle likewise sought to resist suffering. However, following the tragic poets, he also sought to embrace acceptance of suffering by emphasizing flexibility and the relationship between value and susceptibility to pain, and warned about the dangers of too much resistance to suffering through closing off risk (Nussbaum 1986). Indeed, Aristotle combines acceptance of suffering and resistance to suffering through seeking a ‘middle way’: between too much vulnerability and too much control, between too much pain and too much loss of humanness and goodness, between too much safety and too much impoverishment, between too much fragility and too much strength. The Aristotelian ‘middle way’ seeks a balance between, ultimately, being human and living a ‘good life’ that is beautiful, good, but fragile and a living a ‘good life’ that ceases to be beautiful and good because it is no longer fragile. In addition, it is Aristotle’s view that:

central human values are available and valuable only within a context of risk ... [and] that these central human values ... cannot be found in life without ... risk.... Their nature *and* their goodness are constituted by the fragile nature of human life. (Nussbaum 1986: 341)

It is not only that suffering can lead to the valuable and the beautiful, then, but also that it is *only* within the suffering wrought by the riskiness of human life that certain values can actually manifest.

In complete contrast is the response to suffering found in songs from Hillsong. Of all the literature I examined, without doubt the simplest response evident in the thematic tension between acceptance and resistance, and to the problem of suffering in general, is the ultra expression of resistance found in Hillsong songs. While all other material I read revealed an awareness of a continuum of possible responses, or at least recognition of the existence of other responses, these songs are so attenuated to

resistance that it manifests largely as absence. That is, the language of the songs I examined gives little or no direct awareness that suffering exists. The overwhelming emphasis is on love. Examples include: “I love you, I need you” (Hillsong 2002: song 35), or “Jesus, my first love ... my eternal love” (Hillsong 1999: song 21), or “I’m falling in love with you” (Hillsong 2002: song 55), or “I soar on the heights of your love” (Hillsong, 2002: song 73), or “I love you more than life” (Hillsong 2004b: song 13), or “Jesus, love You so much” (Hillsong 1999: song 42), or “I keep falling in love with You” (Hillsong 2002: song 38). It is this emphasis on love, with the concomitant absence of suffering, that answers, I suggest, the question, “Why does [such]... singing so often seem so trivial?” (Frost 2006: 23): it can seem trivial because it avoids suffering and the place of suffering in human life by concentrating heavily on love and other ‘positive’ emotions.

Any references to suffering are by inference: in referring to deliverance from suffering by God in which “I’m found safe within Your harbour” (Hillsong 2002: song 65) and am made rich and strong (Hillsong 1999: song 2); or to suffering in the past tense in which God’s love “rescued me” (Hillsong 2004a: song 48), “delivered me” (Hillsong 2004a: song 40), “lifted me” above and “dissolved” suffering (Hillsong 2008: track 9); or to freedom from suffering in the present life rather than in a future resurrection (Hillsong 2004a: song 22; Hillsong 2005: song 2); or, interestingly, to the road being broken rather than the person (Hillsong 2008: track 9). Such songs relate strongly to the prosperity gospel, with its emphasis on health, wealth, success, and freedom from suffering in this world in which God is “my sun and shield” (Hillsong 1999: song 42).

The response conveyed by the lyrics in these songs is resistance to suffering *par excellence*, pushed to such an extreme that suffering simply ceases to exist, or is only rarely admitted to by inference. While such a simple response is attractive in allowing almost total denial of the problem of suffering in human life, such a solution does not relate to the complexities of human life and the inevitability of suffering that the ancient Greeks so honestly and brilliantly wrestled with. However, Hillsong songs form part of the Western response to suffering and, because they exist within a continuum of great longevity between acceptance and resistance, they actually serve to energize the existence of this thematic tension, rather than to

obliterate it, by engaging with suffering largely through the absence of direct responses to suffering.

While Hillsong songs are exclusive in their response to suffering, the hymns in *AHB* (1977) and *TIS* (2006) indicate that the Christian response to suffering can be inclusive and wide-ranging. Many hymns emphasize God's healing grace and power and the resurrection as ways of dealing with suffering (*AHB* 1977: hymns 532, 265, 55), but there are also some hymns that clearly accept suffering as part of the human condition (*AHB* 1977: hymns 252, 270), and a few that actively embrace an acceptance of suffering (*AHB* 1977: hymn 608; *TIS* 2006: hymns 262, 356). It is noteworthy that redemption from suffering is in the future tense as something to come, unlike the songs from Hillsong where redemption from suffering is in the present tense as something happening today. In the former, there is, in the acceptance of present suffering, also a resistance to that suffering in redemptive hope for the future; while in the latter there is, in the resistance to suffering and the focus on present redemption, also a refusal to accept the existence of suffering in the present.

The Book of *Job* profoundly illustrates the tension between acceptance of suffering, in the character of Job, and resistance to suffering, in the characters of his 'friends'. While Job, despite much grumbling and confusion, accepts his suffering, his 'friends' resist it in their attempts to control it; that is, their resistance is an acceptance *only* insofar as they can control it by explaining it. Job's long lament detailing his woes are given in words of deep and honest suffering in which he wishes he had never been born or seen the light of day and rejects light and life, wishing only for darkness and death (*Job* 3). Against reminiscences of past happiness (*Job* 29), he describes his present misery and despair in terms of being overwhelmed by blackness, turmoil, loneliness, pain, and rejection, in which his "soul is poured out ... and days of affliction have taken hold" and he has become like "dust and ashes" (*Job* 30). However, despite his extreme suffering and the accusatory explanations of his 'friends', Job's acceptance of his suffering does not lead to resignation. Indeed, it is an active acceptance, in which he does not lose faith in God, but continually questions God about his suffering and pleads his innocence (*Job* 10, 31). This is a story in which lack of control is central, which is why Job's 'friends' are at such pains to explain his suffering; because in explaining the suffering, they

think they can then control it. This is preferable to them than the unthinkable alternative: acceptance of suffering as it is with a concomitant and complete lack of control.

The answer eventually provided by God, that he is the creator God, does not answer any of Job's questions. While such an answer restates the Hebrew understanding of God as creator (Wright 2006), the answer also runs against the prevailing emphasis in Deuteronomistic teaching and the Hebrew world-view where God punishes the wicked and rewards the faithful servant. The Job story is not only counter-intuitive; it is rebellious. It is the antithesis of all that is expected from the world and God, yet the story speaks of the acceptance of suffering as a way to God just as it acknowledges the human need to resist suffering by controlling it.

In the secular-atheistic literature, the thematic tension between acceptance of suffering and resistance to suffering is exquisitely balanced and inclusively affirming. As a result, the tension between the polarities is strongly interwoven, becoming powerfully creative and focussed on the ever-pregnant possibilities arising from human suffering. In these stories, the acceptance of suffering is often combined with a resistance to suffering. For example, Dr. Rieux (Camus 1960) accepts the inevitability of the plague and the role of luck in surviving it, yet he is also committed to saving as many lives as possible by resisting the ravages of the plague to the best of his medical ability. Similarly, Shukhov (Solzhenitsyn 1963), while he wants to get home, accepts his harsh life in the labour camp by engaging with life within that suffering; in this way he also resists it to find meaning so that by the end of the day he feels he has been very lucky and has had an almost "happy day" (143). Frankl (2004) also considers that suffering must be accepted as an inevitable part of life and, while survival in the concentration camps often depended on luck, he strongly emphasizes that within the suffering it was always possible to find meaning of significance and value.

Acceptance of suffering can manifest positively, then, or even cheerfully as with Alyosha (Solzhenitsyn 1963) who rejoices in his imprisonment and accepts his suffering as an opportunity to think about his soul. However, extreme forms of the acceptance of suffering can have detrimental consequences resulting in

condemnation or resignation. For example, the possible danger existing in an extreme form of the acceptance of suffering is explored in the character of Paneloux (Camus 1960) who moves from a condemnatory position of judging the plague and its suffering as having only positive characteristics to accepting that he must maintain his faith in God while also fighting against the plague. Camus (1960) also describes the debilitating effects of the extreme forms of both acceptance and resistance that become merely resignation, where people oscillate between apathy and denial as they attempt to deal with their unbearable suffering. Sometimes, resistance to suffering is necessary to keep hope alive, and Frankl (2004) noted that concentration camp prisoners who lost hope died very quickly. There is, in all these works, an emphasis on the combined and interwoven necessity to accept suffering and the need, by whatever means, to also resist suffering.

Acceptance of suffering and resistance to suffering constitute a continuum held in dynamic tension. The value of this tension is that it facilitates movement. In the material examined in this section, there is much evidence for claiming that there has been longstanding movement backwards and forwards along this continuum in Western culture, from *Job* through the ancient Greeks to modern secular-atheistic literature and even to Christian hymns. While extreme polarities are rarely, if ever, helpful, the tension created between polarities fosters and maintains a journey of engagement. Even the songs from Hillsong, at the most extreme point of the resistance polarity, nevertheless, encourage this journey of human engagement with suffering, not by what they say but by what is hidden in the gaps between the words in the Derridean underbelly of the text.

### **3.3 Relationship and Causality**

In this motif, there is a continuum between finding in suffering relationship of some sort to finding in suffering causality of some sort. On the one hand, relationship in suffering refers to the awareness of relationship (to people, God, tasks, interests, values, responsibilities, *et cetera*) and of its central importance to humans despite the presence of suffering. On the other hand, causality in suffering refers to the

determination of the causes of that suffering, and, thereby, to also directly or implicitly determining a solution to that suffering.

The Book of *Job* is a powerful statement about human suffering and relationship, and the self-referential nature of causality. In the responses of both Job and God are revealed concerns with relationship despite suffering, while in Job's 'friends' are revealed concerns only with causation of suffering. Central to an understanding of *Job*, and constituting one of the most significant questions in the Bible, is the Satan's question (*Job* 1: 9) concerning the type of relationship possible between God and humans (MacKenzie & Murphy 1990). Is this a relationship based on causality, where obedience to God results in blessing and disobedience in suffering, or a relationship based on covenantal reciprocity of love and faith despite the presence of suffering? *Job* is quintessentially a treatise about relationship, exploring how the relationship between God and Job (humans) is manifest despite the presence of suffering.

Initially, Job's 'friends', in sitting silently with him in the ashes for seven days, offer their only true comfort: it is a response of relationship *in* suffering *with* the sufferer. When someone is suffering, physically or emotionally or both (as in Job's case), what is needed by the sufferer are not "lessons in theology" but "sympathy and compassion" (Kushner 1982: 76). In suffering it is relationship that is important and valuable to the sufferer, not interminable opinions about the cause of the suffering, useful as these sometimes are. After their initial support, however, Job's 'friends' pursue causative investigations into his suffering. The attractiveness of the causal approach to suffering is that, in explaining suffering, it provides a solution. Moreover, it is a solution that is always fixed and predictable: Job has sinned and is therefore suffering punishment, which can be solved by repentance. Their arguments concerning the link between sin and punishment reflect Hebrew Deuteronomic doctrines of retribution and divine justice, and their speeches become increasingly accusatory and damning of Job as they cogently detail these theological concepts, though in an exaggerated way (Irwin 1962, MacKenzie & Murphy 1990). However, despite the veracity of their explanations they fail to extricate themselves from their human situation. *Job* shows humans to be obsessed with causative rationality and

logic in their approach to suffering and God to be only concerned with relationship within suffering.

Job is not interested in the re-instatement of his material possessions, something his ‘friends’ keep talking about, but in re-establishment of his relationship with God. Suffering pushes us “*outside* reality as commonly defined” (Berger 1967: 43), but that God is present in such suffering is as hard for the faithful to comprehend today as the Job story suggests it was thousands of years ago. It may be that “God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains” (Lewis 1957: 81); however, if honest, most people would rather this were not the case and that life could be as simple and ordered and as easily and logically explained as Job’s ‘friends’ maintain. Nevertheless, God’s answer to Job is not logical and is anathema to much in ancient Hebrew culture. Suffering is not a problem with a solution, just as “God is not a rational problem requiring solution” (Chryssavgis 1994: 62). A logical meaning to suffering might be preferred, but *Job* speaks about a meaning of suffering that “can *become* the point of encounter with God” (Kung 1980: 695). The story points to the foundation of ontological moorings where meaning can be given to suffering and where the wounds are made “sacred” (Rohr 1996: 187), where “God finds and enters the open wound ... not in order to simply comfort but rather to identify with us” (Chryssavgis 2004: 72), where God does not protect “*from* all suffering” but protects “*in* all suffering” (Kung 1980: 695), and where in the midst of suffering we can become “‘God’s language’” speaking to the suffering of others (Kushner 1982: 147).

While Job is unable to understand why he is suffering and repeatedly pleads his innocence, culminating in his ‘oath of innocence’ to God and his ‘friends’ (*Job* 31), he never loses his focus on the primacy of relationship with God. Job, in his suffering, is concerned about his relationship with God and God is shown to also be concerned with relationship, whereas Job’s ‘friends’ are only concerned with the cause of suffering. While such explications are theologically grounded, Job’s ‘friends’ have failed to allow for mystery. They are theological ‘mathematicians’ who study “God as a subject to be analysed, predicted and understood” (MacKenzie & Murphy 1990: 467), and in trying to fit Job’s suffering into causal explanations and solutions they have missed the point that suffering can be relational.



Causality of suffering demands rational explanations and solutions that can obfuscate a perspective that values relationship despite that suffering. This is why Job, despite his suffering, ultimately attains a closer relationship with God and why his ‘friends’ do not and are chastised by God. The answer to the Satan’s question, then, is that the covenantal relationship between God and humans (Job) is reciprocal and exists outside suffering and beyond causality. Suffering becomes not the ground of causal punishment but the ground of relational being which transcends that suffering. The “luminous darkness” (Rohr 1996: 10) of which the Job story speaks requires us to view suffering in a completely different manner to that which we are accustomed, and to that which we would prefer. That suffering may be something beyond simple causality, may be relational for the sufferer with something ‘other’, may be beyond human ‘laws’ of rational cause and effect, and may have no rational solution was something understood by Job, but not his ‘friends’.

In ancient Greek literature is also evident the tension between relationship and causality in approaches to suffering. *Job* and the Greek tragedies hold a privileged place in the succession of Western literature concerned with human suffering that continues to the present day (Irwin 1962). The ancient Greeks embraced in a remarkable and profound manner an articulation and exploration of suffering that largely grounded it within an anthropocentric, rather than a theological, framework. In so doing, their insights are particularly relevant to the increasingly secular and atheistic modern West. The ancient Greek tragic poets and Aristotle were concerned to demonstrate both the inadvisability of attempting to control the tragic in human life through determining causality and the importance of relationship. Conversely, Plato is concerned with isolating the causes of suffering, thereby offering a solution to the problem of suffering.

In the works of Aeschylus, Nussbaum (1986) identifies attention to the relational link between suffering and human goodness because suffering acknowledges the reality of human life as it is and to the interconnection between personal suffering and value. In the *Agamemnon*, the tragedy of Agamemnon stems from his failure to fully acknowledge the centrality of relationship: he “*knows*” Iphigenia to be his daughter, yet his defiant response to his predicament is that he “*doesn’t really know* that she is

his daughter” because he tries to avoid suffering by denying relationship (Nussbaum 1986: 45).

Concerned with the tragic in human life, Nussbaum’s (1986: 81) approach to Sophocles’s *Antigone* positions the ‘tragic view’ as foundational to the expression of, and relational to, human life:

Haemon’s advice is that the true way of being humanly civilized requires .... [balancing] self-protection with yielding.... The ‘razor’s edge of luck’ requires in this way the most delicate balance between order and disorder, control and vulnerability.

The play ends with the Chorus suggesting that “the spectacle of this tragedy is itself an orderly mystery, ambitiously yielding, healing without cure, whose very harmony ... is not simplicity but the tension of distinct and separate beauties” (Nussbaum 1986: 82). Ancient Greek tragedy, in positioning tragedy and suffering within the parameters of what defines the human and as part of, related to, and expressive of a person’s goodness, presents human life as inseparably both ‘tragic’ and beautiful.

Plato, as with Job’s ‘friends’, is concerned to explicate the causes of tragedy and suffering in human life, and thereby to offer solutions. Whereas Job’s ‘friends’ position their arguments concerning the causation of suffering within a theological framework, Plato positions his arguments within the human realm of cause and effect. Both approaches are concerned with logic and predictability and reflect the same human need to control human suffering by attributing it to incorrect human thinking and behaviour; sinful thinking and behaviour resulting in divine punishment in the case of Job’s ‘friends’ or irrational thinking and behaviour resulting in human-created suffering in the case of Plato. While Plato’s position softened a little from the *Republic* and *Symposium* to the *Phaedrus*, he, nevertheless, argues that only through science can tragedy and suffering be avoided, situating the cause of suffering in lack of scientific reason and the attainment of the ‘good life’ in the supremacy of hard, unemotional scientific deliberation (Nussbaum 1986).

For Plato, ‘relationship’ is only concerned with the link between causality and suffering and its prevention, whereas Aristotle, following the Greek tragic poets, is

concerned with a relational approach to suffering that acknowledges the interrelationship between suffering, human life, goodness and values. In accepting rather than resisting suffering, Aristotle is able to emphasize relationship over causality. Where Plato stresses science and simplicity in his concern for the causality of suffering, Aristotle stresses the human condition and complexity in his concern for relationship within suffering; and where Plato defines individual responsibility as a life lived purely by rational logic in an effort to live a 'good life' and to avoid and prevent tragedy and suffering, Aristotle defines individual responsibility as tied to relationships and living a 'good life' that is inseparable from tragedy and suffering (Nussbaum 1986).

The importance and value of relationship existing within suffering is explored in all three secular-atheistic texts. Relationship is shown to be both individual and corporate. In *The Plague*, Rambert moves from a position of denying he is part of the plague-ridden city because he is focused only on his relationship with his wife, from whom he is separated, to finally realizing he is connected to the people and to the fate of the city and is not separate from them or it: "I know that I belong here whether I want it or not. This business is everybody's business" (Camus 1960: 170). Relationship can manifest in apparently strange forms, individually as well as corporately. For example, Grand (Camus 1960) aspires to be a writer and repeatedly re-works the same sentence, yet works tirelessly to help the victims of the plague. Shukhov and other inmates, despite antagonisms, are described in detail working extremely hard to build a wall, taking pride in what they do, and later Shukhov's detachment and their guards are joined together in the mutual goal of getting back to the camp before other detachments in a relationship that transcended prisoner and guard (Solzhenitsyn 1963).

In the concentration camps, Frankl (2004) considered survival depended not only on individual attachments to such things as faith, memories of family, and interests but also on comradeship between inmates. The tensions between individual inmates trying to survive is held between individual need and corporate need. In such endeavours, despite extreme suffering, it is relationship, whether individually or communally, that flourishes in spite of the suffering and from within that suffering. A focused examination on the cause of suffering is absent in these works. In these

examples of extreme situations of suffering concern with the causality of that suffering ceases to be of much, if any, significance, and it is relationship, in one form or another, that is paramount and is explored widely and profoundly.

In examining the songs from Hillsong, however, it would seem that causality of suffering is also of little or no significance to those not in situations of extreme suffering; that is, to affluent, middle-class Australians. Hillsong songs seem to only emphasize by inference, if anything, that sin is causative of suffering and love removes all suffering. Underlying this position is a tacit acceptance of the Deuteronomistic position that God blesses the faithful and punishes the wicked. This viewpoint dominates adherents of the prosperity gospel, some of whom claim that all believers who have accepted Christ as their saviour have “‘a title deed to prosperity’” and are guaranteed protection of life and property, job promotion, material prosperity, and permanent success (Bloomfield 2003: 12, quoting Copeland). This simplistic, tightly defined, and exclusive approach to life, separated by some four thousand years of Western history, bears some striking similarities to the approaches taken by Job’s ‘friends’.

Moreover, the overwhelming focus on love that characterizes the Hillsong songs is very much concerned with an individual relationship with God, rather than a communal relationship with God that characterizes many of the hymns in *AHB* (1977) and *TIS* (2006). The virtual indifference to causality of suffering, then, stems not from an emphasis on relationship achieved despite and from within suffering but from a denial of suffering. The “often insipid, cloying, and romantic” love songs, where “pop-style love songs” are sung “to Jesus, confessing...undying love for him in the same way that pop idols sing to a boyfriend or girlfriend” (Frost 2006: 22), epitomize many Hillsong songs. They do not reflect a concern with relationship born of suffering, but with relationship born of resistance to suffering.

In such songs there is virtually a complete avoidance of the whole problem of suffering and the idea that within suffering there could be a deeper relationship with God (as in *Job*), with value and beauty (as in the ancient Greek tragic poets and Aristotle), or with simple human comradeship (as in the secular-atheistic literature) is absent. In contrast, while some hymns in *AHB* (1977) and *TIS* (2006) refer to a

causal connection between sin and suffering, many more emphasize relationship with God, some emphasize relationship between suffering and joy and between God and redemption, and some emphasize God as being with people in their suffering rather than removing it. Emphasizing the relational nature of God with his creation, hymn 265 (*AHB* 1977) reminds the Christian that “Bane and blessing, pain and pleasure, / by the cross are sanctified”. Hymn 93 (*AHB* 1977) links God’s love and human suffering, reminding the Christian that “when human hearts are breaking / under sorrow’s iron rod, / then they find the self-same aching / deep within the heart of God”. The depiction of Christ holding the hand of a suffering person, offering help and hope, and walking with that person (*TIS* 2006: 356) speaks of relationship to be found within suffering, something frighteningly anathema to the type of blissful love relationship with Jesus that characterizes the songs from Hillsong.

Relationship in suffering can have religious associations (as with Job and in many hymns), or communal associations (as with Shukhov and Rambert), personal associations (as with Grand or Frankl), or existential associations (as with the ancient Greek poets and Aristotle). However expressed, such relationship within suffering sustains people and draws them into a wider and deeper relationship, whether with God, with other people, with themselves, or with what it is to be human. On the other hand, causality of suffering, as represented by Job’s ‘friends’ and Plato, is always concerned with calculation of the causes of suffering. Unlike the ‘acceptance / resistance’ motif, the ‘relationship / causality’ motif is consistently and highly polarized in Western culture. The value of this oppositional tension is that it strongly facilitates recognition that these two polarities are grounded in vastly differing, if not antithetical, foundational assumptions. Relationship in suffering is concerned with the embrace of union; causality of suffering is concerned with the precision of calculation.

### **3.4 Chaos and Certainty**

The West’s response to suffering also plays out along a continuum between chaos and certainty. This third motif is revealed in a fascinatingly complex manner that

hinges on how suffering is framed. One framing rests on the assumption that in suffering chaos and certainty are oppositional, while the other framing involves the idea that in suffering chaos and certainty are interwoven, rather than oppositional. The former pursues an understanding of suffering that endeavours to control chaos through the creation of certainty, while the latter embraces it through the finding of certainty within chaos. As with the first motif, then, this motif is one that also oscillates considerably.

In the secular-atheistic literature examined, this oscillation moves between recognition that some certainty can be imposed on suffering but equally that chaos plays a central part in suffering. However, any such imposition of certainty on the chaos of suffering originates from within that chaos, not outside it. These texts describe living with the chaos of suffering and doing one's best despite the lack of certainty. Meaning comes not from imposing some external certainty on suffering, but from finding it within the chaos of suffering. In particular, Frankl (2004) emphasizes that meaning must be found within suffering. The certainty of the suffering of concentration camp life precluded certainty in controlling life, but within the overwhelming suffering experienced in the camps an individual could achieve certainty in a personal response to suffering. According to Frankl (2004: 88), once a person "knows the 'why'" for his or her existence then that person can "bear almost any 'how'". Certainty, for those who are suffering, arises from self-awareness of personal worth, not from the certainty of controlling or preventing suffering. Suffering, then, becomes a task: a "single and unique task" for each person to attend to with commitment and responsibility (Frankl 2004: 86).

*One Day in the Life of Ivan Denisovich* (Solzhenitsyn 1963) explores a similar emphasis in finding certainty within the chaos of suffering through attention to small tasks and actions. Shukhov describes an old man who had spent many years in camps and prisons and had received no amnesty: "Whenever one ten-year stretch ran out they shoved another on to him right away" (Solzhenitsyn 1963: 122). Nevertheless, despite the gross chaos of such an unfair system that had physically ravaged him, this old man had developed a ritual when eating. He sat with a straight back, unlike the other inmates hunched over their food, and instead of placing his meagre ration of bread on the dirty table he set it on a piece of "well-washed rag" (Solzhenitsyn 1963:

123). Such rituals can give much needed certainty within the chaos of suffering. Life in the camps was harsh and brutal and, because luck played such a crucial role in survival, the chaos of suffering was ever-present. Yet, within such suffering, in which the chaotic nature of suffering was certitude rather than distant possibility, there could be found certainty within that chaos in small things. For example, Shukhov and his team, despite the freezing cold, end up committed to building a good wall. Certainty came not from controlling the external world but in securing a little certainty in how the wall was built. Within suffering, then, while it may not be possible to control its unfair and chaotic nature, some certainty can be secured in control of, and commitment to, the small thing, whether a rag upon which to place bread or a well-constructed wall.

The finding of some sort of certainty within the chaos of suffering is also evident in many of the characters in *The Plague* (Camus 1960). Tarrou, while he considered that the plague (the suffering endemic in the human condition) “was never over, and there would be more victims because that was in the order of things” (Camus 1960: 208), always chose to be on the side of the victim. Tarrou, who considered he had the plague long before he “came to this town and encountered it here” (Camus 1960: 201), is not being fatalistic or negative about the suffering plight of humans, merely accepting that the plague, suffering in general, is constitutional in humans. For Tarrou this is a certainty, and in the chaos of suffering wrought by the plague (and life) his siding with the victims and his commitment to helping them provides a certainty in his life – a life that, in the chaotic nature of the plague, he loses only after the plague has begun to recede.

Similarly, Dr. Rieux works tirelessly for the victims of the plague and, while admitting that they “knew next to nothing” (Camus 1960: 109), finds certainty in doing his job properly. Despite all the medical attempts to treat and control the plague and the suffering it caused, it proved to be a power beyond medical solution, yet Dr. Rieux operates in the personal certainty that he must save as many lives as he can. When Tarrou succumbs to the plague Dr. Rieux recognizes that all his medical options are of little use, something he learnt through repeated failure in treating plague victims. In the end, all that could be done was to help the victims and wait for the plague to run its course. Certainty of successfully defeating the plague was not an

option but, within this state of chaos, certainty could be found in responses to the plague. In addition to characters such as Tarrou, Dr. Rieux and eventually even Rambert, the townsfolk also worked tirelessly to assist where possible and, “as long as the epidemic lasted, there was never any lack of men” for grave-digging or stretcher-bearing duties, even though many of these volunteers died from the plague (Camus 1960: 145). The plague is both chaos and certainty in that suffering is certain but the unfolding of this suffering, and when it will next strike, is chaotic. Towards the end of the novel, Dr. Rieux comments that while the plague has disappeared there can be no “final victory” (Camus 1960: 251) because it waits and will strike again.

Such interweaving of chaos and certainty is decidedly absent in the songs examined from Hillsong. Due to the extraordinary emphasis on love and a life free from suffering, these songs indicate that Christians are apparently very happy, very much in love with their all-powerful Lord, and any pains or fears they have experienced have been swept away by their victorious God. The pervasive emphasis, often inferred, on the absolute certainty that God has (note the past tense) “washed away my tears, gave me joy and freedom” (Hillsong 2002: song 65) resonates through all songs I studied in what amounts to a weighty credo of the presence of God’s love and the absence of suffering. There is an overwhelming emphasis on miracles happening today (Hillsong 2004a: song 22). Not only is suffering either nonexistent or existed only in the past but the idea that life can be chaotic and suffering endemic in that chaos is absent. While this perspective on suffering is undeniably appealing, as opposed to a perspective that embraces suffering and chaos, it is firmly at one extreme polarity in a continuum where the other point, chaos, has simply vanished, and therefore does not have to be considered. There is not so much an oppositional tension between chaos and certainty in these songs as the static, unchallenged dominion of certainty where both chaos and suffering have ceased to exist.

While many hymns in *AHB* (1977) and *TIS* (2006) emphasize the certainty of faith in God, God’s supremacy, and God’s grace, the absolutist position of Hillsong songs is generally absent. However, only in some hymns is there recognition of the inexplicable connection between certainty and chaos. In particular, hymn 262 (*TIS* 2006) directly addresses the interwoven complexity of suffering, where “God’s nakedness” and the “play of chance” concretise simply but powerfully both the chaos



and certainty of suffering. In the first verse the human need for strength and certainty and God's response point succinctly to the tension between chaos and certainty:

When pain and terror strike by chance,  
with causes unexplained,  
when God seems absent or asleep,  
and evil unrestrained,  
we crave an all-controlling force  
ready to rule and warn,  
but find, far-shadowed by a cross,  
a child in weakness born. (*TIS* 2006: hymn 262)

The chaos of life, its suffering and unfairness, is answered not by a victorious God removing all suffering and injustice but by a vulnerable child and death on a cross. Such hymns embrace the paradoxical connection in suffering between chaos and certainty, rather than the domination of the latter over the former. These hymns also inversely help explain the attractiveness of songs from Hillsong Church, in which certainty does not merely dominate chaos but largely eclipses it, because the polarity of certainty is a pain-free and a safe place to be unlike the frightening and painful place afforded by the polarity of chaos.

In *Job* and ancient Greek literature can be seen examples of both polarities from differing perspectives. *Job* "is one of the few books ... in the bible that says life isn't about control" (Woods on Rutledge 2009: 15). *Job*'s 'friends' epitomize the certainty of religious and theological dogma that provide consistent and coherent explanations for God, the world, and suffering. They want control of the world and of God, and use theological certainty to justify the chaotic suffering that has befallen *Job*:

The difference between *Job* and his advisors is that they want and demand clarity and order from the universe. They want to foresee what God will do. *Job* wants to see God. (Rohr 1996: 34)

While theological and biblical discourses on *Job*, specifically, and suffering, generally, emphasize the 'unknowability' of the *why* of suffering and the centrality of faith and relationship with God the praxis of this, as opposed to the theory, is problematic. For *Job*'s 'friends' the chaotic nature of *Job*'s suffering is *only* explainable from the certainty of their theology, yet God offers "no word of explanation ... only a thunder-and-lightning demonstration of the fact of facts,

namely that man cannot measure the will of God” (Campbell 1968: 148). For Job, on the other hand, the chaotic nature of his suffering underpins the certainty of his faith and his relationship to God. The certainty of Job’s ‘friends’ originates from outside chaos and is oppositional to it, whereas Job’s certainty exists within the chaos of his suffering. The Job story speaks about suffering, as with God, not being a static equation that can be spelled out and numbered in a rational, logical order.

It is out of the chaos of the whirlwind that comes Job’s answer from God. This answer is a non-answer, a solution that is no solution, because the “God who speaks to Job out of the whirlwind is not an answer giver or a problem solver” but a God who, like a whirlwind, “is dynamic, in motion, while our definitions are always static” (Rohr 1996: 157, 150). God is beyond “human categories”, and it is categories that Job’s ‘friends’ demand but that are “totally shattered by the Almighty ... and remain shattered to the last” (Campbell 1968: 148). While categories provide certainty, in *Job* God disrupts any such certainty with chaos. There is a chaos in God’s creation that is difficult to either accept or handle, and when the chaos hurts human instinct responds by trying to explain, which is really both a denial and a rejection of what suffering is. “God is not just ... creator of perfect order. God is also trickster, exception, foil, and surprise. God is personal and not just predictable force” (Rohr 1996: 160). God becomes, enigmatically, chaos *and* certainty; moreover, God can be certainty veiled *within* chaos – “the absolutely unattainable, the irreducibly different” (Williams 2000: 75). Job, through his suffering, comes to understand this, but his ‘friends’ achieve no such understanding.

The ancient Greeks have broached the tensions between chaos and certainty with the admirable dignity of pursuing in depth both polarities in their struggle to fathom how best to approach suffering. On the one hand the tragic poets and Aristotle, while accepting the chaotic nature of life and suffering, suggest an approach that seeks to gain some certainty but not at the expense of being human. Plato, on the other hand, promotes certainty as the only way of subduing the chaos of life and suffering and of preventing it from occurring. Plato’s thought follows Pythagorean reasoning that “what is measurable or commensurable is graspable, knowable, in order, good; what is without measure is boundless, elusive, chaotic, threatening, bad” (Nussbaum 1986: 107). Platonic certainty originates not from within chaos but from outside it and in

opposition to it, viewing chaos as something to be mastered. Aristotelian certainty, on the other hand, arises from within chaos, and is inextricably linked to this chaos. The sealing off of “certain risks” in life to avoid suffering means “closing certain happenings”, an outcome that Plato privileges as ensuring the ‘good life’ and that Aristotle rejects as impoverishing the ‘good life’ (Nussbaum 1986: 420).

The Western response to suffering evident in this third motif oscillates between chaos and certainty in a vibrant dynamism that extends from interwoven holism to oppositional division. While certainty is undoubtedly necessary for human life to flourish, the presence of chaos is always problematic, particularly in the area of suffering. The presence of suffering acutely raises the polarities of certainty and chaos and elicits responses that either recognize their interconnected coexistence, such as in the secular-atheistic texts, some hymns, Job, the ancient Greek tragic poets and Aristotle, or emphasize their separateness, as in Job’s ‘friends’, Plato and Hillsong songs. On the one hand, the tension between the polarities is very much intertwined, pointing to the existence of certainty and chaos being inextricably tied together, even, enigmatically, of certainty *within* chaos. On the other hand, the tension between the polarities results in one *or* the other, certainty *or* chaos, in a tension that is divisive. The value of this motif is in crystallizing these long-standing twin characteristics to be found in the Western response to suffering in which certainty is sought either from within chaos or from outside chaos.

### **3.5 Descent and Ascent**

In this examination of Western approaches to suffering, the fourth motif reflects a tension crucial to understanding how the West has struggled to deal definitively with suffering. If previous motifs characterized aspects of the human journey with suffering, this motif characterizes the type of journey itself. Descent into suffering is seen either as a journey into avoidable suffering or a journey through which ascent from suffering is undertaken. Conversely, ascent from suffering is seen either as a journey away from suffering or as a destination, or secondary journey, achieved through a journey that first descends into suffering. There are, then, two possibilities:

either a direct ascent from suffering, away from descent into suffering, or descent into suffering that leads to some sort of ascent from suffering.

In Christianity is a profound and complex reflection of the tension between descent and ascent. This is due to the nexus in Christianity between the two polarities of descent and ascent that both draws them inextricably together but also maintains the opposing tension between them. From the resultant paradox arises the possibility of varying foci, and it is in these differences that arise the powerful tensions between descent and ascent, exemplifying clearly the two possibilities that characterize the Western journey with suffering: ascent from suffering can be either be a focus on ‘escape’ or transcendence, but the latter only arises from descent into suffering.

The extensive indexing in the examined hymnals provides a microcosm of life in hymns ranging from of joy and celebration to death and suffering. While many hymns repeatedly refer to the power of God as creator and redeemer, many equally recognize the presence of suffering in human life, and some are in part a prayer asking to share in the suffering of Christ on the cross as the way to God and love. Ascent from suffering to God is through descent into suffering. For example, hymn 252 (twelfth century) from *AHB* (1977) asks: “Grant us with you to suffer, Lord”, emphasizing the place of suffering in achieving love and joy. These positive emotions are achieved through negative emotions (suffering, sorrow, and shame), rather than through the healing of the latter by God. In a similar vein, hymn 270 (nineteenth century) from *AHB* (1977) also links suffering, love and faith. This hymn speaks to the centrality of Gethsemane and Calvary in both expressing and experiencing that faith, reminding the Christian of “the worth of pain” in the journey of faith and the vanquishing of pain and death by Christ.

Two modern hymns by Wren, contained in *TIS* (2006: hymns 262, 356), deal explicitly and powerfully with the problem of suffering in the world. Wren (*Milgate & Wood* 2006: 260) considers that ““to the person who sits bowed in depression, there is no good news in being invited to join the celebration next door””. For Wren the good news is to be found in the person of Christ who lived a human life fraught with pain, desolation and meaninglessness and who walks with Christians in their own suffering. In hymn 262 (*TIS* 2006) is found a concern with responding directly

and honestly to suffering, recognizing the place of chance, and openly pointing to and questioning the apparent weakness and vulnerability of God and Jesus. Described as “one of the best modern hymns on the subject of pain and suffering” (*Milgate & Wood* 2006: 182), this hymn does not shy away from the depth, chance, and absurdity of human suffering by concentrating on God’s healing power or on the resurrection. Rather, the focus is on a God who knows what it is to be subject to chance, to fragility, to pain, and to death. It is only through such suffering that the resurrection is both realized and understood. The hymn points to both the experiential and relational nature of the descent into suffering and the ascent from suffering through this descent in the life, death and resurrection of Christ.

Similar responses to suffering can also be found in hymn 356 (*TIS* 2006), in which Wren paints a very stark picture of the absurdity that lies at the heart of Christianity: the apparent foolishness of a God who suffers and dies, yet promises life eternal and freedom from suffering. The language is bare, direct, and honest and speaks powerfully to the suffering person. What can constitute unhelpful references (for a suffering Christian) to God’s healing power and joyful praises of the resurrection are absent in this hymn. Indeed, the emphasis is on the suffering of Christ as “a scarecrow hoisted high, / a nonsense pointing nowhere”, and on the absurdity of his words in this contemporary world of “dazzling progress”. The hymn focuses on the presence of this suffering “clown” in a Christian’s “deepest emptiness” and “pit of life’s despair”, where Christ “can name our hidden darkness / and suffer with us there”. Finally, the hymn, while acknowledging the resurrection, does not do so in a burst of Christian zeal and joyous acclamation. Rather, it depicts Christ as choosing to walk as a friend with the suffering person into the darkness of “the night”.

In his notes about this hymn, Wren (*Milgate & Wood* 2006: 260) writes that ““to anyone who feels life to be empty and meaningless happy stories about resurrection and grace can be an alienation””; yet it is in Jesus, whose life was ““emptied of all meaning, drained out in bleak distress”” and who was left forsaken by God in the ““greatest crisis of his life””, that the suffering person may find affirmation and companionship. The absurdity of the cross is manifest as God’s chosen way of self-revelation, as a nexus between descent into suffering and ascent out of suffering. Indeed, the cross is at once a symbol of resurrection and a symbol of suffering and

death, with the former realized only through the latter. Drawing on his background in classical art and archaeology, Nigel Spivey (2008: Programme Five) considers the Christian cross / crucifix to be unique:

It's the one single image that's working on the human mind in two opposing ways. It's a terrifying image, representing pain, loss, and suffering, and yet at the same time it's an image that reassures, one that holds out hope. This combination has made the cross one of the most powerful symbols ever.

However, the tension between descent and ascent in Christianity is variously interpreted and emphasized. Indeed, concern with ascent often obscures or ignores descent altogether. Easter Day and Pentecost are preferable for many Christians, particular those belonging to Pentecostal churches, than are Ash Wednesday and Lent. Yet, essentially Christianity is a religion of ascent through descent, not ascent alone. The prosperity gospel, exemplified in the songs from Hillsong, is tied to ascent as ascent only, denying or avoiding ascent that comes through the suffering of painful descent. Such a journey of ascent only is only representative of life for some people some of the time, and for many, perhaps never. When life is full of health, success, and happiness, songs from Hillsong are eminently appropriate, magnificently celebrating life, love, and gratitude to God for abundant blessings. Sentiments such as falling in love with Jesus (Hillsong 2002: song 55), soaring high in God's love (Hillsong 2001: song 43), "made glad" by God (Hillsong 2004a: song 40), dreams coming true today (Hillsong 2004a: song 22), and being rescued by God's love (Hillsong 2004a: 48) resonate throughout the songs from Hillsong. Indeed, the prosperity gospel dovetails perfectly with a life of love and plenty. However, although Hillsong Church has brilliantly and effectively fused the individualism, consumerism, and emphasis on pleasure of modern Western culture with Christianity it has been criticized for its shallowness, commercialization of Christianity, and its emphasis on consumption and entertainment (Power 2004, Connell 2005, Frost 2006).

Taking the same tack, but from a different perspective, Plato is also focussed exclusively on ascent from suffering. Plato considers that ordinary people make life prone to tragedy and suffering by attaching value to the wrong things because they

are “misguided” by their “distinctively human nature”, which is “buried deep in some barbaric slime”, and are therefore unable to see clearly; Plato’s argument is that “correct perception would come from a standpoint that is more than human, one that can look on the human from the outside” (Nussbaum 1986: 138). The Platonic position was that “there is available in the universe a pure transcendent standpoint, from which the whole truth of value in the universe is evident” (Nussbaum 1986: 342) and that such truths could only be seen from the correct perspective of the philosopher. Nussbaum (1986) observes that such Platonic argument is “dangerously circular” because for Plato (and Socrates) “appetitive activity is rejected from a point of view that has already purified itself of appetite” (155); hence, the Platonic perspective that determines what is of value and what is valueless is “from the viewpoint of one who no longer sees his characteristic human needs as genuine parts of himself” (154).

For this reason Plato cannot see the value that may come from descent into suffering, and from within which may come ascent from suffering, because ascent from suffering is equated with avoidance of suffering through the rule of reason in the ascetic, philosophical life. In the ancient Greek tragic poets and Aristotle, however, the embracing of human life in totality not only accepts descent into tragedy and suffering as inevitable and unavoidable but also as a necessary precursor for the full flowering of the best in a human being, where excellence “could not be made invulnerable and keep its own peculiar fineness” (Nussbaum 1986: 2). In this sense, the close linking of descent into suffering and ascent from suffering, particularly the presence of human excellence to be found only within the human vulnerability to suffering, is closer to the later Christian position than is Plato’s.

Similarities to the Platonic position on ascent from suffering can also be found in a different time and in a very different culture. In its oral form the story of Job predates Plato’s thinking by possibly some one thousand five hundred years, yet Job’s ‘friends’ also approach suffering through rationality. However, whereas Plato is concerned with a scientific rationality that can prevent suffering, Job’s ‘friends’ are concerned with a theological rationality in which ascent away from suffering is dependent on obeying God and descent into suffering is caused by disobeying God. Job accepts his descent into suffering, finding within it his ascent towards a closer

relationship with God. Some scholars argue that the ‘nice’ ending to *Job*, where Job’s health and wealth are restored, was added much later (Irwin 1962, Rutledge 2009) as the original ending, concerned so much with descent into suffering, was possibly unpalatable. This underlies a significant problem with descent into suffering; the journey that descends into suffering is truly awful. Little wonder, then, that some Christians would later emphasize the happy ending to *Job* and the resurrection of their Lord over any descent into suffering as seen in Job’s plight or in the crucifixion. Yet, “[p]ain instinctively repels” at the same time as it is “privilege ... and opportunity” (Irwin 1962: 408). In his pain Job eventually finds such privilege and opportunity, ascent (via descent into suffering) into the presence of God, whereas his ‘friends’ see Job’s pain in no such terms and only as an example of descent into suffering caused by disobedience.

In the secular-atheistic literature, as in *Job*, the descent into suffering is a very real and present fact. The possibility of focussing on the judgement of God, as with Job’s ‘friends’, or on love, as in songs from Hillsong, or on methodological self-control, as in Plato, in order to avoid suffering is simply not even remotely possible. This twentieth-century literature represents extreme suffering, so descent is a given, and ascent is explored through that imposed descent into terrible suffering. In these texts, the finding of meaning is paramount, and is achieved through ascent from suffering via descent into suffering. Frankl (2004), drawing on his experiences in Nazi concentration camps, developed a form of psychotherapy based on the pursuit of meaning as opposed to pleasure. This subtle shift of emphasis sees a radical re-orientation to meaning and suffering, where instead of asking questions about the meaning of life and suffering, Frankl (2004) sees life as questioning each person about the meaning in his or her life, whatever the situation. Similarly, in the Soviet labour camps (Solzhenitsyn 1963), it was possible to find ways of ascending suffering through the imposed descent into suffering, whether non-religious, as with Shukhov, or religious, as with Alyosha, where the journey is one of hope and thankfulness amid deprivation and suffering.

Camus’s vision of suffering, and its impact on people, is best seen as a combination of bleakness and hope. In the descent into suffering to which the people of Oran are subjected to by the plague it is only from within this suffering that they can ascend in



some way out of the suffering. Dr. Rieux at the bedside of his dying friend, Tarrou, feels that “all a man could win in the conflict between plague and life was knowledge and memories” (Camus 1960: 237). Dr. Rieux’s memory of Tarrou would be mixture of knowing life and death: of “a living warmth, and a picture of death” (Camus 1960: 237). Dr. Rieux later reflects that what he and his fellow-citizens had in common were the certitudes of “love, exile, and suffering” (Camus 1960: 246), and that his chronicle of the plague was a memorial that “might endure” as a record of what they all suffered and fought against and that stated “quite simply what we learn in a time of pestilence: that there are more things to admire in men than to despise” (251). The plague was a catalyst for both “the bane and the enlightening of men” (Camus 1960: 252). This rather profoundly and poignantly combines the pain of descent into suffering with the knowledge that can come from ascent out of such a descent into suffering. As with Aristotle, out of suffering can come the best that is possible in a human, even though the suffering may be the worst of experiences.

In the tension between ascent and descent can be seen long-standing Western concerns to fathom a way of journeying with suffering. On the one hand, as seen in the positions taken by Job’s ‘friends’, Plato, and songs from Hillsong, is a journey of ascent away from suffering, that concentrates, because of its tight focus on ascent only, on ways to avoid or overcome or ignore suffering. However, where Job’s ‘friends’ approach suffering in a concretised theology of divine retribution or blessing, Plato approaches the problem of suffering from a rational perspective of rigorous self-control, and the songs from Hillsong reveal not a rational response but an emotional response grounded in ‘feeling good’. All reject descent but for quite different reasons: for Job’s ‘friends’ descent signifies disobedience to God, whereas for Plato descent points to a lack of methodological control of life, and in Hillsong songs descent seems not to exist. On the other hand, as seen in the perspectives of Job, the ancient Greek tragic poets and Aristotle and in some Christian hymns and the secular atheistic texts, is a journey with suffering that combines both polarities, in which ascent from suffering takes place from within descent into suffering. Where confinement to one end of the continuum can only reflect a part of what constitutes human life, the con-joining of both polarities within a single journey embraces a far wider understanding of human suffering and life. This motif reflects how the human

journey with suffering has manifested in Western culture. It represents both the powerful human need for ascent from suffering and the profound human acknowledgement that within descent into suffering is the means and possibility both of ascent from suffering and of the flowering of what is most valuable, poignant, meaningful, and beautiful in the human condition.

### **3.6 Conclusion**

These four motifs represent one possibility of approaching how Western culture has sought, and continues to seek, for ways to make sense of suffering. Neither comprehensive nor definitive, this approach, nevertheless, reveals certain long-standing preoccupations in the West about how to deal with suffering. While the tensions in these motifs are revealed in various shades and combinations, the motifs themselves have remained unchanged over some four thousand years of Western history.

Drawing on ancient Hebrew, ancient Greek, Christian, and modern secular-atheistic literature I explore a number of tensions that characterize how the West has approached the problem of suffering and found these responses to be strikingly similar in their emphases and fluctuations. The literature reveals four consistent tensions that oscillate between polarities of ‘acceptance and resistance’, ‘relationship and causality’, ‘chaos and certainty’, and ‘descent and ascent’. Essentially, these tensions suggest two enduring perspectives. One is concerned with resistance to suffering, emphasis on causality and control of suffering, and the need for ascent away from suffering. The other is concerned with acceptance of suffering, emphasis on relationality and recognition of the presence of chaos, and the possibility of ascent from suffering within descent into suffering. The former is oppositional and restrictive, viewing suffering as unwanted, unnecessary, without value, and anathema to human life. The latter is inclusive and holistic, seeing suffering as a constituent part of human life within which is found special value, meaning, or attributes, often not available without that suffering.

Situating the contemporary Western framing of depression within an historical context is to position it as part of a long-standing human journey with suffering characterized by enduring tensions between the same polarities, rather than as a linear journey towards a specific destination of definitive solution. Although the modern West is a secular-atheistic society its roots are embedded in its Judaic-Christian and Greco-Roman past, and exploring these roots elucidates both origins and patterns of thought central to understanding how Western culture arrived in the twenty-first century in its present form. My research for this thesis indicates that the contemporary framing of depression in the West is situated very much at, or towards, the resistance, causality, certainty, and ascent end of the Motifs of Suffering, reflecting attitudes to suffering evident over at least four thousand years of Western thought.

These motifs assist in comprehending the wider Western conceptualisation of suffering in which depression is situated. They are useful as a way of specifically understanding the diversity of focus evident in current depression research that views depression as an illness caused by brain abnormalities (Rubinow 2002) or as associated with cultural factors such as ethnicity (Karasz 2005). In addition, the Motifs of Suffering are useful as a way of understanding some major issues with how depression is currently viewed in the West. For example, concerns in both medicine and sociology about the current framing of normal sadness as depression (Blazer 2005, Horwitz & Wakefield 2007) and about the emphasis in medicine on science to furnish understandings of depression (Summerfield 2006a, Williams 2000b) can be meaningfully explored by relating them to how suffering has been approached in the past. Similarly, the value and importance of story as a way of both revealing and communicating ideas about depression (Karp 1996, Dowrick 2004) can be seen as part of a long history of stories dealing with how individuals deal with suffering.

The danger of the Procrustean bed is well illustrated in the Motifs of Suffering in that points on the continuums between the eight polarities, and particularly the polarities themselves, make self-referential sense. However, these points can appear nonsensical or irrelevant when seen from other points on the continuums. Thus, for example, the emphasis of Job's 'friends' on causality of suffering is immaterial to Job who is concerned with relationship, or Aristotle's emphasis on acceptance of

suffering is irrational from Plato's perspective of resistance to suffering. To view and judge all perspectives according to one perspective is not only to force these 'others' to fit this 'one' perspective, which results in the 'others' rejected as illogical, irrelevant, or unacceptable, but also to miss any potential value in these 'other' perspectives and to fail to understand or appreciate the origins, internal coherence, and validity of these perspectives. Thus, to view depression as *only* illness (depression as demon) is to disregard or overlook seeing depression as also gift (depression as dæmon)<sup>4</sup>. The challenge in discussions about suffering, or depression, is to not only maintain an awareness of historical context but to not privilege one point on any continuum as inevitably superior to others. To this end, in researching and constructing a theoretical framework for this thesis I have been mindful of the value of both historicity and plurality. In the next chapter, I introduce the theoretical model by which I examine the contemporary framing of depression.

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<sup>4</sup> For clarification and further explanation of my use of 'demon' and 'dæmon' see the footnote on page 30 of Chapter One.

# Chapter Four

## The Quatrefoil Model of Historical-Cultural Framing

**We do not see the lens through which we look.**

(Ruth Benedict)<sup>1</sup>

**The water takes its colour from the vessel containing it.**

(Junayd of Baghdad)<sup>2</sup>

**[T]here are two kinds of scientists.... [O]ne group are hunters, they have a strong need to discover unambiguous fact, this is a permanently true fact ... forever.... Then there are butterfly chasers. Butterfly chasers fall in love with a certain aspect of nature, they know all facts are transient [and] science is always changing.... And they want to find out something, even if it's a brief glimpse.**

(Jerome Kagan)<sup>3</sup>

### 4.1 Introduction

This thesis pivots on the premise that historical-cultural framing determines how people, corporately and individually, come to view and understand their world and themselves. Applying such a premise to depression is a fascinating endeavour. By historical-cultural I am referring to antecedent features in Western culture that exert influences over contemporary culture in how the world is both perceived and explained. The construction of a theoretical model from which to examine the contemporary Western framing of depression is the final stage in my long journey into theory. In this chapter, I introduce the ‘Quatrefoil Model of Historical-Cultural Framing’, which provides another way of exploring how depression is framed in the

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<sup>1</sup> Dundes 2004: 173

<sup>2</sup> Nicholson 1975: 88

<sup>3</sup> Mitchell 2007: 3

modern West. Through its application to the depression literature (see Chapters Five to Nine) I hope to enrich the current multifaceted and growing discussions about depression.

My theoretical model draws attention to characteristics within contemporary Western society that have antecedent origins. Cultural features, such as how the world is viewed, largely determine how the world is then understood. These perspectives do not arise *de nouveau*: they are shaped by historical processes whereby the ways in which the world was viewed and understood in the past still determine and influence how it is viewed and understood today. This occurs despite often considerable historical change in other areas, such as technology or the place of women or developments in medicine. History and culture form a complex interweaving of warp and weft that constitute the ‘cloth’ of any society. While the patterns imprinted on the cloth can change radically, the fibres themselves do not.<sup>4</sup> A Weberian perspective focussed on history is, I suggest, particularly useful in facilitating a meta-perspective attendant to the nuances of history because it situates research of cultural framing within an historical context, thereby facilitating a broad view. In using the term ‘historical-cultural’, rather than ‘cultural’, I am both emphasizing and drawing attention to the powerful, potent, and often hard-to-detect force of history to influence the present.

The theoretical model I develop consists of five areas that I term historical, interpretative, meaning, public, and future orientations. These Western orientations to the world facilitate exploration of different factors contributing to how the West frames any subject, including depression. I am using the word ‘orientations’ in the sense of the positions or directions in which ideas about depression are focussed and have developed. Hence, in my discussions I examine how Western antecedents focus a perspective on the world, and therefore depression, in a particular way (historical orientations), which then influences directions in the interpretation (interpretative orientations) and meaning (meaning orientations) of depression. These then influence the focus in material transmitted to the public about depression (public orientations).

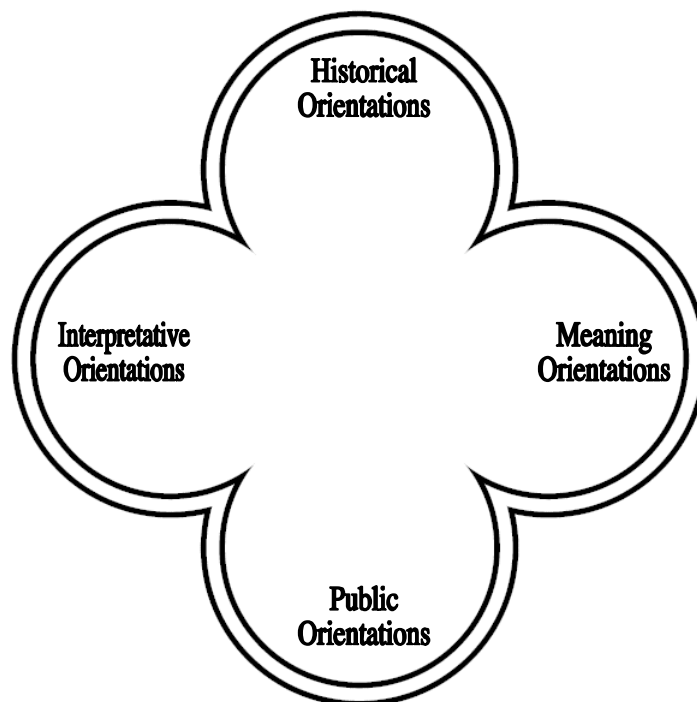
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<sup>4</sup> In the period I am looking at in Western culture this observation is, I believe, generally valid (at least for the purposes of my discussion); but perhaps over longer periods there *are* changes in the ‘fibres’, characterized by slow evolution or even by radical transformation. This point, though interesting, is outside the scope of my study.

Finally, my discussions explore, given these four orientations, a possible direction for the future (future orientations). This theoretical model, as with the Motifs of Suffering (Chapter Three), facilitates plurality and tension. In so doing, I anticipate that it will provide places and spaces for both hegemony<sup>5</sup> and liminality, and I also hope that it will also encourage a new nexus in which respectful dialogue is the salient characteristic.

## 4.2 Introducing My Theoretical Model

The Quatrefoil Model of Historical-Cultural Framing structurally consists of four intersecting circular ‘leaves’ representing different, but overlapping, aspects of historical-cultural framing (see Figure 1 below).



**Figure 1**

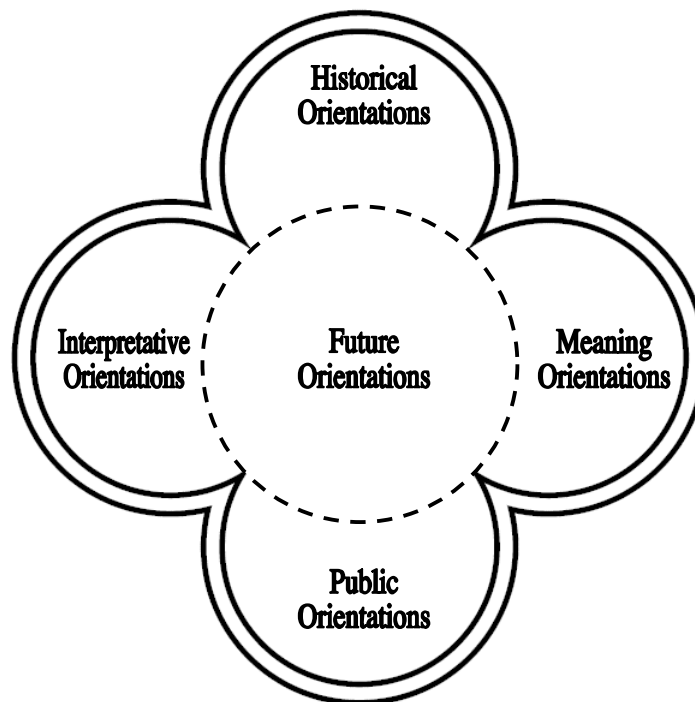
Together they represent one way of examining how humans orientate themselves to the world. In Part Two I use these categories to examine the medical and sociological

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<sup>5</sup> I am aware that ‘hegemony’, definitionally, does not allow for the existence of ‘other’ (see Chapter Nine, pages 282-283, for further discussions of my use of ‘hegemony’).

approaches to depression. The first ‘leaf’ (‘Historical Orientations’) of my theoretical model provides an historical perspective on antecedents of contemporary Western culture influencing how the world is approached in secular modernity (see Chapter Five). The second ‘leaf’ (‘Interpretative Orientations’) is concerned with how the world is interpreted (see Chapter Six) and the third ‘leaf’ (‘Meaning Orientations’) with what meaning is assigned (see Chapter Seven). The fourth ‘leaf’ (‘Public Orientations’) examines the approaches to depression provided for the general public (see Chapter Eight).

In addition, in the centre of the quatrefoil is a circle structurally formed by the intersection of the four ‘leaves’ of the quatrefoil and the area between them (see Figure 2 below):



**Figure 2**

This central circular ‘leaf’ is the fifth and final part of my theoretical model and is concerned with ‘Future Orientations’. It is created both by the overlapping of the four orientations (historical, interpretative, meaning, and public) themselves and from the void between them, providing a place and a space for the ongoing development of future possibilities. Particularly underlining the organic structure of



my theoretical model, it is not defined with a solid line because it is always in the act of ‘becoming’. In this fifth and final part of my theoretical model I discuss how depression could be approached in the future in a way that is inclusive, rather than exclusive, and fosters respectful coexistence of difference, rather than rejection of difference (see Chapter Nine).

I consider this theoretical model potentially useful for exploring any aspect of contemporary Western culture because it is specifically designed to encourage an approach concerned with *why* we think what we think, rather than specifically concerned with *what* we think. One important element in each of these orientations is the presence of what I have termed ‘inconvenient voices’. In his seminal lecture on science, Weber (1991: 147) explains that he considers a central aspect of the relationship between a teacher and student is that the teacher directs student attention to “inconvenient facts”. Following Weber, I see it as a primary task of the sociologist to reveal and point to ‘inconvenient voices’, and the ‘inconvenient facts’ they raise, that unsettle “party opinion” (Weber 1991: 147). These ‘inconvenient voices’ (sometimes representing merely variety of opinion, sometimes offering alternative ideas, sometimes engaging in strident disagreement, and sometimes presenting radically different perspectives) all tend to destabilize, or at least question, the hegemony of dominant paradigms and all point to problems in Western rationalism concerned with point of view, interpretation, and meaning.

In addition, my theoretical model importantly has the capacity to both value and critique because it is able to facilitate tensions without privileging one viewpoint over others. All the orientations are characterized, directly or indirectly, by tension between polarities. Largely these tensions are between singularity and plurality, exclusivity and inclusivity, and the ‘sanctioned’ view and the ‘other’ view. The organic structure of my theoretical model facilitates recognition and inclusion of these dynamic tensions, as well as the creative possibilities that can potentially arise from them and from the interactions between them. This theoretical model facilitates an alternative perspective on the contemporary Western framing of depression and I consider that the possibilities it proffers for analysis and discussion are both rewarding and challenging. In the following sections, I first explain each of the orientations before discussing them in relation to my topic of depression.

## 4.2.1 Part One – Historical Orientations

The first ‘leaf’ of my Quatrefoil Model is founded on the idea that the way the world is viewed in contemporary Western culture is determined by how it was viewed in the past. By ‘historical orientations’ I am referring to current ways of approaching the world that are inherited from past ways of approaching the world. I am not especially concerned with the specific content of these views, but with the framing that lies behind them. Indeed, the content of views can often change radically, even when the manner in which the world is viewed has not changed. These historical orientations are both the genesis and impetus from which the other orientations arise and proceed. It does not determine the development of content, but of form. They are the skeletal frameworks upon which societal paradigms and cultural narratives develop. However, such development is not rigid, pre-determined or linear, and in the fifth ‘leaf’ (Future Orientations) the organic nature of my theoretical model is particularly in evidence.

Examining and understanding the influence of history on contemporary Western society has interested many scholars in recent times, for example Habermas, Gadamer, and Foucault. Weber approached this problematic by exploring historical religious antecedents, while Derrida developed his concept of logocentrism, and Levinas devised the concepts of Same and Other. The first part of my theoretical model specifically draws on Weberian concepts concerning the transformation of religions and aspects of the Protestant ethic, the Derridean concept of logocentrism and the Levinasian approach to the relationship between Same and Other.

Historical orientations in the contemporary West manifest as concerned with how the world and the individual are viewed. Such an approach proceeds firmly in the belief in the supremacy of Western rationalism (particularly science), so much so that it tends to overshadow the foundational premise of science that it is always provisional and based on uncertainty, not certainty. These beliefs in certainty and world-mastery stem, as Weber observed, from the total world-view that secular modernity inherited from its religious past. Historical orientations, because of their assumed validity as the ‘one true’ perspective on the world, can sometimes be difficult to discern, and tend to be revealed in both ‘seen’ and ‘unseen’ ways. Indeed, sometimes their

existence is best demonstrated by way of Derridean deconstruction and an approach characterized by a type of *via negativa*<sup>6</sup>. The historical orientations reveal in the contemporary West a peculiar situation where the total world-view is buffeted by the existence of plurality of view, creating dynamic tensions between a singularity of view and a plethora of views that are particularly evident in the tension between scientism and alternative perspectives. It is the latter, the ‘inconvenient voices’, that particularly help reveal the restricted nature of a single and dominant viewpoint.

In application to the depression literature (both medical and sociological) in Chapter Five, the historical orientations reveal a pronounced emphasis on belief in world-mastery via Western rationalism, particularly science, and on the rejection, intolerance, or diminishing of other viewpoints. Medicine, in its assumption that it is the only correct way of looking at health and illness, displays both a singularity of vision and a belief in world-mastery that Weber considered the modern secular West had inherited directly from its Judaic-Christian heritage, that Derrida saw as a logocentric substitution of one centre by another, and that Levinas saw in the reduction of Other to Same. However, medicine exists and functions in a world of evident plurality in the variety of competing opinions and points of view, both within and without medicine. In the resulting tensions between them can be seen the second characteristic that Weber identified Western secular modernity had inherited from its religious past: the re-emerging pluralism of indigenous religions. Instead of coexistence between plural viewpoints, however, there is the pursuit of an agenda of domination. Such domination is facilitated by the power of the medical elites to perpetrate this agenda. The sociological critique of the medical position accepts the premise of a total world-view behind the medical world-view by attempting to re-direct it through criticisms of the medical position and / or through an emphasis on social and cultural factors as significant. The existence of ‘inconvenient voices’, even though they tend to be of the sort that simply raises issues or problems with existing approaches, point directly to difficulties with the emphasis on certainty of perspective based on a total world-view and world-mastery evident in the Western framing of depression.

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<sup>6</sup> The term *via negativa* refers to approaches used in both philosophy and religion whereby a subject is approached through negation. For example, in Christianity *via negativa* (also known as *via negationis*, or negative or apophatic theology) is the discernment of what God is by describing what God is not (O’Collins & Farrugia 1991: 15-16, 154, 260; Macquarrie 1977: 107, 203-205).

## 4.2.2 Part Two – Interpretative Orientations

The second ‘leaf’ of my theoretical model is concerned with how the world is interpreted. Ways of interpreting the world, which I have called ‘interpretative orientations’, reveal a Western preoccupation for approaching the world as ‘problems to be defined’ and ‘problems to be solved’. These interpretative orientations proceed in a belief in rationality (science) as the total world-view and are concerned with defining and solving the identified problems in a rational manner. In this way, both the unacceptable effects and results of such ‘problems’ can be resisted and, thereby, eliminated. This part of my theoretical model examines how the contemporary West is characterized by a pervasive emphasis on scientific rationality as *both* the perspective and the answer to virtually every aspect of life. All fields of knowledge, whether in the sciences or humanities, proceed on the basis of scientific-rationalist principles that determine the correct way to do things – how to do science, paint, study society, or write, *et cetera*. However, within this approach to the world are evident tensions between differing interpretative positions.

One way of discussing these different stances is to focus on the source of the ‘problem and solution’ approach endemic to Western interpretative orientations. The second part of the Quatrefoil Model is based specifically on the concepts constituting Weberian Western rationalism and the rejection of irrationality in the Protestant ethic, the Derridean Rousseauistic Interpretation, and the Levinasian observation of the Western impulse to label and control by changing Other into Same.

The ‘problem’ with the ‘problem and solution’ approach is, I suggest, that it fails to actually see the problem (or subject), but instead draws discussions inevitably and inexorably into disputation about how to define the problem and about how to solve the problem. The resultant emphasis is on proving the validity of one particular perspective over another and on demonstrating other perspectives to be erroneous, inadequate, or limited in some way. Interpretative orientations furnish all the benefits of Western rationalism in their emphasis on defining problems and solving problems in a specific and peculiarly rationalist way, but also the disadvantages of being unable to acknowledge plurality and of viewing ‘other’ interpretations as irrational, or at least partial or inferior in some way. The subsequent contestation between

different interpretative positions produces a variety of ‘inconvenient voices’ that directly reflect the fixation of Western historical orientations on a total world-view and belief in world-mastery.

In Chapter Six, I apply this second part of my theoretical model to the depression literature, both medical and sociological. In particular, this approach enables a meta-perspective on interpretative responses to depression, demonstrating that they are characterized by resistance. The ‘problem and solution’ approach is not merely revealed to be the overwhelming perspective from which depression is considered but to be so totally consuming that alternative approaches to depression are virtually absent. However, the depression literature, while reflecting both the emphasis on centred interpretations (the Derridean Rousseauistic Interpretation) and a particular type of rationality (Weberian Western rationalism), reveals a decided lack of awareness that its interpretations are centred and are representative of a particular rationality. It is this unawareness that leads to disagreements because, inevitably, differently centred interpretations, or differently framed rationalities, are going to clash. In Levinasian terms, the impulse to always reduce Other into Same so it can be known and controlled also reveals both this need to centre interpretations and the source of disagreements. The way in which Other is made into Same will vary depending on how the interpretative stance is orientated, or how it is centred or rationalized. The presence of ‘inconvenient voices’ reveals limitations with the emphasis in Western rationalism on resisting anything perceived as problematic through a problem and solution approach. Overall, however, the interpretative orientations are quintessentially characterized as problem-solving ventures, hence the emphasis in the depression literature on solving the problem of depression.

### **4.2.3 Part Three – Meaning Orientations**

A focus on meaning constitutes the third part of my theoretical model, and in using the term ‘meaning orientations’ I am specifically referring to how meaning is assigned and understood in the contemporary West. The meaning orientations reveal a Western focus almost exclusively on causality as the fount of all meaning. In the determination of cause and effect, meaning is furnished in a specifically rational

manner founded on evidence-based science. In this way, meaning other than rational meaning concerned with causality is removed from the equation of calculation. However, while the provision of meaning is singular and specific, such close attention to causation does not prevent considerable differences of opinion and contestation regarding meaning. Weber's ideas surrounding rationality and meaning, Derrida's two interpretations of interpretation, and Levinas's concepts surrounding the knowability of Same and the unknowability of Other are foundational to the third 'leaf' of my Quatrefoil Model.

The meaning orientations reveal not only the considerable benefits that science can provide in terms of explanations of causality, but also the problems attendant to such a singularity of perspective: namely, the plurality of meaning. The problems of a total world-view operating in a world of plurality are exemplified by the presence of 'inconvenient voices'. The existence of such 'inconvenient voices' strengthens the individual freedom to choose that Weber saw resulting from modern Western culture, while also facilitating a deeper cognizance for differing perspectives and their values. Different perspectives on the world produce different interpretations that in turn produce different meanings. The meaning orientations facilitate an examination of how meaning in the contemporary West is determined by its rational framing. The framings tend to be self-referential and self-validating because they are centred on specific ways of understanding the world that are matters of belief, not matters of fact.

When applied to the depression literature in Chapter Seven, the meaning orientations reveal a focus on causality and the existence of 'inconvenient voices' that raise questions about the contemporary framing of depression. Unfortunately, this tends to lead to contestation of meaning rather than expansion of meaning. However, this part of my theoretical model assists in explicating the sources of these disagreements over the meaning of depression and is therefore suggestive of a wider approach to meaning. In the area of depression, the medical interpretative orientations tend to be translated directly into meaning orientations. It is this singular act, both confounding and conflating causality with meaning, that has resulted in the Western framing of depression confusing causality of depression with meaning of depression. Causality is *one* meaning; it provides cause and effect meanings. However, as a constituent

part of Western rationalism it is delimited by its very nature that excludes broader and alternative meanings. Sociological research tends to focus on specific social-environmental issues, such as gender or unemployment, or medical issues, such as treatment efficacy, that likewise constrict meaning to narrow concerns of cause and effect. More than in any of the other orientations, ‘inconvenient voices’ in the meaning orientations challenge existing approaches to depression.

#### **4.2.4 Part Four – Public Orientations**

The fourth ‘leaf’ of my theoretical model concerns how the previous three orientations (the historical, interpretative, and meaning orientations) have interacted and coalesced into a common Western cultural narrative, which I refer to as ‘public orientations’. In particular, this part of my theoretical model examines the relationship between the individual and the specialist, drawing on Weber’s concepts of a total world-view and the role of the elite, Derrida’s centred interpretation, and Levinas’s concepts of Same and Other. The public view on any particular aspect of society is always determined by history and the interpretations and meanings that those in power promulgate and perpetuate. However, while there is never a direct translation of the ideas of the elite into the views of the laity, the public orientations reveal the potency of dominant paradigms to influence public perceptions and understandings.

The public orientations reveal the ‘public face’ of the historical, interpretative and meaning orientations and are characterized by an approach of ascent in a journey and destination defined by the health professional and travelled by the individual. What is available for the public on this journey does not reflect all aspects revealed in the historical, interpretative, and meaning orientations. That is, the public orientations reveal a simplification of information and expose a delimiting of possibilities for the individual. In application, this part of my theoretical model discloses that the journey can only be one of ascent in which the emphasis is on individual responsibility for self-monitoring and on the role of the professional in solving problems and guiding the laity in what to think and how to act.

When this part of my theoretical model is applied, in Chapter Eight, to material about depression designed for the public (primarily the Australian website *beyondblue*), the journey of ascent from depression is laid out as a clear and well-defined route. In particular, the contestations within medicine and between medicine and sociology that are so evident in the academic depression literature have virtually, if not completely, disappeared. Depression is presented as a well-understood and treatable illness. Individuals are advised that depression is a serious and increasing health risk and are strongly urged to be vigilant in monitoring themselves and to report to professionals for treatment if they experience listed symptoms for a specified period of time. The concerns of sociology regarding areas such as medicalization, professionalization, and surveillance medicine are absent from the public orientations to depression available in the contemporary West. The public orientations reflect the intentions of the health professionals to improve depression literacy as well as the necessity to simplify the message about depression in order to achieve this goal. Representative of the public orientations to depression in the West, the *beyondblue* website, while demonstrating a comprehensive and well-presented approach to depression, delivers a perspective on depression that is narrow and exclusive of both contestation and other possibilities. This simplified approach to depression is devoid of the ‘inconvenient voices’ that revealed problems of perspective, interpretation, and meaning in the previous three orientations. The absence of ‘inconvenient voices’ is a salient feature of the public orientations to depression, pointing to the cost of producing a definitive and simplified message about depression for public consumption.

#### **4.2.5 Part Five – Future Orientations**

The most exciting part of my theoretical model, which I call ‘future orientations’, focuses on approaches and possibilities for the future and arises from the preceding four orientations. It was also very much the last to be developed, largely motivated by a certain discomfort about where both Weber and Derrida leave their respective discussions. As discussed in Chapter Two, both reveal a sense of loss and both are somewhat lacking in the specifics of ‘where to from here?’ in terms of the irreconcilability of rationalities and interpretations and the predicament of the



individual in the contemporary secular West. Notwithstanding the positive aspects of Weberian and Derridean discussions, living “the *différance* of ... irreducible difference” conceived of as an “unnamable ... infant” (Derrida 1978a: 293) or having to choose between “warring gods” (Weber 1991: 153) as well as “integrating” irreconcilable value orientations (Brubaker 1984:109) while imprisoned in an “iron cage” (Weber 2001: 123) beneath “a polar night of icy darkness” (Weber 1991: 128) seem to me to present intriguing and valuable ideas for philosophical and sociological debate, but are, practically speaking, rather unhelpful. This no doubt in part explains the work of scholars reviewing and extending the ideas of these theorists in a variety of directions (for example, Habermas 1984, Alexander 1987, May 1997, or Kearney 1999) and the work of other scholars concerning modernity or post-modernity and the place of the individual (for example, Giddens 1990, 1991 or Fox 1993, 1998). The fifth and final part of my theoretical model results from similar concerns and represents my approach to addressing the questions of ‘how to?’ and ‘where to?’ from here.

In particular, this fifth aspect of my theoretical model reflects its overall organic nature. Although determined by what ‘was’ (historical orientations) and what ‘is’ (interpretative, meaning, and public orientations) it is always open, hence the broken line that defines its shape. This orientation is conceived to be both pragmatic and innovative. That is, it is designed to recognize the inevitability of a dominant viewpoint but also the existence of the ‘other’ in Western culture, the problems that arise when these two meet, the value in both, and possibilities for a way forward that is inclusive. The underlying principle of this fifth orientation is respect. It is my contention that without respectful dialogue between different positions the future will remain divided and discussion adversarial and closed. An ethic of respectful dialogue, even “‘holy envy’” (Landau 2007: 1, quoting Stendahl), ensures that voices other than the dominant voice do not merely have a say but that genuine communication between the dominant paradigm and those holding differing paradigms is both facilitated and promoted.

Plurality of views is not tolerated well in the West by the dominant paradigm, hence the presence of ‘inconvenient voices’. It is from the interplay between the dominant viewpoint and the other viewpoints, between the dominant voice and the

‘inconvenient voices’ (some being more marginal and inconvenient than others), that arises the possibility for future growth and exploration. The values inherent in some ‘inconvenient voices’ are analogous to the liminal position Weber saw characterizing the values of ethical substantive rationality under the dominance of formal rationality: they are only found “‘at the edges’” (Kalberg 1980: 1176), expressed in small intimate groups (Weber 1991) and voluntary organizations (Kalberg 1980, Seidman 1984). However, while such small groups might appear to have little influence on Western culture, historically they have sometimes had a marked impact.

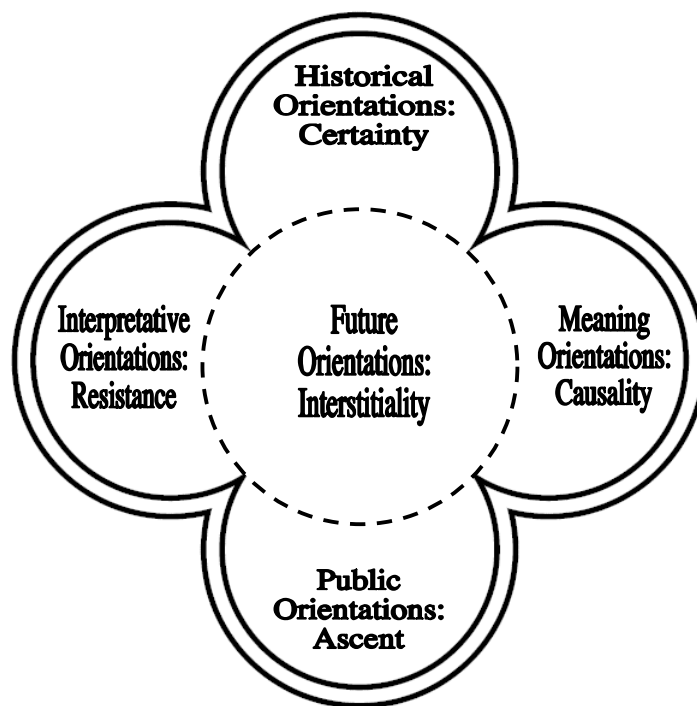
In application to my topic of depression in Chapter Nine, this part of my theoretical model attempts to facilitate both plurality of views and recognition of their values. I specifically examine other examples of marginal voices and how dialogue has subsequently brought about a wider perspective and, in some cases, change to the dominant perspective. While it is unlikely that the dominance of the medical paradigm of depression in the contemporary West will radically change in the near future, there are signs of exploration beyond the medical position from within its own ranks and recognition of issues raised from sociology. In this way, I hope that in the interstitiality between different approaches respectful dialogue can increasingly facilitate the provision of ‘a place and a space for tears’, even if it is located ‘at the edges’, and subsequently lead to new possibilities for the future.

### **4.3 The Quatrefoil Model and the Motifs of Suffering**

The orientations constituting the ‘leaves’ of the Quatrefoil Model, in application to the depression literature in Chapters Five to Eight, reveal themselves to be strongly linked to the Motifs of Suffering I discuss in Chapter Three. At the time these motifs were initially created, I had no inkling they would relate so directly and so strongly to these four orientations. However, in the course of constructing my theoretical model and then applying it to the depression literature it became apparent that the Motifs of Suffering were not only a valuable background to these orientations but also reflected the essence of each of these orientations in terms of how depression is approached and understood. While examination of the depression literature and the

research for, and eventual creation of, a theoretical model was very much symbiotic, only in hindsight did I realize that the work done on the Motifs of Suffering was also both crucially central and fundamentally synergetic to this organic process of growth.

A central characteristic in the orientations, as with the Motifs of Suffering, is tension. I suggest that these tensions in the interpretative, meaning, and public orientations stem from the tensions in the historical orientations between a total world-view and plurality, between rationality and irrationality, and between the medical elites and the laity. Concomitantly, I also discovered that the manner that these tensions played out in each of the orientations was particularly reflective of one of the Motifs of Suffering (see Figure 3 below):



**Figure 3**

The contemporary framing of depression, particularly evident in the medical literature, reveals such a focus at one end of each of the continuums (certainty, resistance, causality, and ascent) constituting the Motifs of Suffering that the other ends (namely chaos, acceptance, relationship, and descent) became so ‘other’ as to exist, like Levinas’s Other, only to be eradicated and changed into their polar opposites where they can be named, defined and controlled. Only the presence of

‘inconvenient voices’ prevents this totality, even though their existence is often at ‘the edges’. In the fifth and central part of my theoretical model concerned with future orientations, the four Motifs of Suffering (‘chaos / certainty’, ‘acceptance / resistance’, ‘relationship / causality’, and ‘descent / ascent’) and the four orientations (historical, interpretative, meaning, and public) are drawn together into an interstitiality of creative possibility that fosters the potential of another way of looking at depression founded on respect and coexistence. In such an interstitiality, ‘inconvenient voices’ transform into ‘voices’ because difference is embraced and valorized, not devalued and rejected.

However, the Quatrefoil Model, as with the Motifs of Suffering, is a rationalist construction. Both are frameworks providing vehicles for studying depression and suffering. As such, they are ‘ways of knowing’, not ‘*the* way of knowing’, and are productive of ‘types of knowledge’, not ‘*definitive* knowledge’. That these theoretical models are useful, complementary, and interrelated to each other indicates only that they are helpful perspectives because “knowledge is always a biased summary of many possible positions and alternatives” (Turner 1996: xiv). Viewing the frameworks and research used in this study as perspectives that are partial and transient in nature is in keeping with Weber’s epistemological approach in the social sciences that emphasizes “Nietzsche’s so-called ‘perspectivism’” (Turner 1996: xiv).

#### **4.4 Advantages and Disadvantages of My Theoretical Model**

The difficulties and pitfalls for all researchers embarking on any sort of study of human society or culture when the researchers themselves are always historically, culturally, and linguistically embedded *within* their own society are well-established and researched across various disciplines; for example, such issues are evident in the work of Weber, Habermas, Derrida, and Gadamer. Perhaps these issues are no more simply and beautifully expressed, though in entirely different historical periods, cultures, and contexts, than by Ruth Benedict and Junayd of Baghdad. Saying essentially the same thing, they express the fact that we are historically and culturally bound, even though this is not readily or easily seen.

Ruth Benedict's oft-quoted and famous observation that "[w]e do not see the lens through which we look" (Dundes 2004: 173) is a reminder that any study of culture is always through a 'cultural lens' and that the findings are a perspective only, not a fact devoid of cultural and historical influence. In a similar way, the insight offered by the ninth century Sufi mystic Junayd of Baghdad (Nicholson 1975: 88) points to the very simple fact that "[t]he water takes its colour from the vessel containing it" and not the water itself. This saying (Nicholson 1975) was used several centuries later by Ibn al-Arabi to illustrate his belief in the unity of all faiths despite apparent divergence and, much as Weber would later warn about the dangers of value spheres and rationalities exerting influence and control beyond their parameters, to warn against interference of one belief system in another. If water is seen as representative of any aspect of human life it becomes obvious that when placed in a coloured vessel, representing a particular perspective or paradigm, then that aspect, be it sadness, God, or science, *et cetera*, will take on the colour of the vessel containing it.

A major advantage of my theoretical model is that it embraces these insights, but a major disadvantage is that it, too, is both a lens through which I look as well as a vessel that colours the water within it. However, this should not discourage attempts to try understanding human societies and cultures, to try understanding how the lens or vessel colours what we see. One way of attempting such an understanding is to examine from what these items are constructed. In so doing, it may be possible to glimpse aspects of the functioning of the 'lens' or 'vessel,' even if never the 'lens' or 'vessel' itself. My theoretical model, and its application in this thesis, represents just such an attempt. As with all theoretical models, then, mine has both advantages and disadvantages: it facilitates an historical-cultural approach to depression, but is restricted by the very thing it seeks to explore.

In addition, I devised the Quatrefoil Model of Historical-Cultural Framing to be characteristic, to use Kagan's terms, of a "butterfly chaser" interested in catching glimpses of things and not a "hunter" interested in catching 'true' facts and certainties (Mitchell 2007:3). It is a theoretical model that is suggestive rather than rigid: it emphasises inquisitiveness over solution, fascination over definitiveness, questions over answers, and respectful dialogue over hegemonic decree. Further, even visually, the quatrefoil itself is also representative of my theoretical model in

that it is a rounded object, often used in art and architecture, suggesting softness and movement and openness, rather than an angular object, like the geometric square, suggesting a closed perspective that is hard and immovable<sup>7</sup>.

Finally, I see this theoretical model as organic; something that can grow, change, and even die. It is, somewhat like Deleuze's distinction between 'arborescent' and 'rhizomatic' thinking and writing (Colebrook 2002), not a step-by-step process delineated by movement from A to Z but an organic process of unfolding which cannot be predicted or controlled. However, it is inclusive, facilitating, in application, paradigms that are linear as well as other possible approaches that are more organic. It thus incorporates both in a plurality that does not judgementally distinguish between them, but fosters a Deleuzian potential of creative possibility out of apparently antithetical positions. These characteristics are particularly apparent in the fifth part of my theoretical model concerned with future orientations.

What, then, is the point of creating and using a theoretical model that by my own admission has what some may see as disadvantages, if not flaws? The Quatrefoil Model of Historical-Cultural Framing is restricted: in a Weberian sense it is contained by its own rationality, in a Derridean sense it is centred, and in a Levinasian sense it has changed 'Other' into 'Same'. What is the point of suggesting a theoretical model that can be criticised for the very things that my model professes to reveal? Moreover, it is like a 'butterfly chaser', is soft and movable, and is organic. My answer is that it encourages a different way of thinking and a different perspective, even though that thinking and that perspective are still curtailed by the cultural framing it seeks to reveal and explore and even though its organic nature renders it vulnerable and incomplete. In admitting its shortcomings, I acknowledge the difficulty in studying any aspect of culture, particularly with an emphasis on openness, respect, inclusivity, and plurality: all theoretical models and cultural studies are necessarily fraught exercises and are necessarily only ever partial.

Scholars (*e.g.*, Dallmayr & McCarthy 1977, Held 1980, Ormiston & Schrift 1990) have wrestled hard to formulate ways of addressing the difficulties of transcending

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<sup>7</sup> See 'Appendix A' for more details on the quatrefoil image and why I selected it to represent my theoretical model.

history, culture, and language and of achieving understanding and interpretation of modern society. That such theorizing and debate continues, and will perhaps always remain unresolvable due to differing viewpoints and interpretations, is testimony, I suggest, that any sort of cultural-historical-societal study should only ever claim to be one perspective, and perhaps only ever a partial perspective at that. Acknowledging the restricted potential and vulnerability of my theory, specifically, and my study, generally, is not an admission of their failure but of their strength. As Gadamer explains, there can never be a single correct interpretation because “a successful interpretation involves a ‘fusion of horizons’” (Dallmayr & McCarthy 1977: 288). In addition, I am alert to Popper’s assertion (1972: 266) that “[w]henver a theory appears to you as the only possible one, take this as a sign that you have neither understood the theory nor the problem which it was intended to solve”.

Gerth and Mills (Weber 1991: 26) observe that one of the reasons that the writings of Weber are so frustrating and so difficult to read is his concern to provide a balanced perspective; hence, “his prose is full of clauses and reservations”. A fundamental characteristic of my theoretical model is that it be balanced and always open to possibilities. I prefer to see the Quatrefoil Model of Historical-Cultural Framing as something organic, something that can grow and change or, as Weber (1991: 138) insisted should be the salient characteristic of science, something “to be ‘surpassed’ and outdated” because it will raise “new ‘questions’”. If one day I achieve this then my hope that both this theoretical model and this thesis encourage discussion will have been successful.

However, I do appreciate that my approach, with its emphasis on historical-cultural framing, engagement, and respectful dialogue, may be uncomfortable to some. In addition, my theoretical approach is undoubtedly also somewhat subversive of any hegemonic position because it is inclusive. It both values and comments on differing paradigms, privileging none, and fosters plurality and dialogic coexistence, viewing tensions as positive sources of discourse and potential growth. The presence of counterclaimants to any theoretical model is always to be expected. Indeed, it is to be appreciated, applauded, and desired because dominance of any position is unhelpful. Fundamentalism of any type will always lead to the assigning of difference as ‘other’, but those willing to consider other possibilities will, it is hoped, engage in

respectful dialogue with other voices. Such dialogue may lead to unexpected and surprising places. It is such hope that underpins this thesis, generally, and my theoretical model, specifically.

## 4.5 Conclusion

A concern with explicating how it is that the world is viewed in a particular way and how it can be understood in relation to the individual has been of particular and continuing concern for many theorists (*e.g.*, Deleuze, Gadamer, Habermas, Ricoeur). The theoretical framework devised for this thesis is my attempt, based on the ideas of three influential theorists, at examining perspective and understanding. It is designed to be neither comprehensive nor definitive; indeed, rather than prescriptive and absolute, it is intentionally suggestive and organic of an ‘other’ way of studying the world and our place in it. Applicable to other areas of cultural study, this theoretical model facilitates another perspective on depression that embeds discussions within the historical-cultural milieu of the West and promotes plurality of opinion and the valuing of different opinions.

The microcosm of contemporary approaches to depression is, I suggest, best understood and studied through the lens of the macrocosm of Western culture. This is why I advocate that exploring the framing of depression is so important to elucidate understandings of *why* we think what we think about depression, not only of *what* we think about depression. In this way, I think the centrality of history and culture as powerful forces influencing contemporary discussions concerning depression are made explicit. To that end, the theoretical framework I developed is based on Weberian, Derridean, and Levinasian concepts because I think they are particularly pertinent to my project as they are all concerned with Western ways of understanding and living in the world.

In Chapters Five to Nine, I apply this quintipartite theoretical model (comprising historical, interpretative, meaning, public, and future orientations) to the depression literature, creating my ‘story’ of depression in five parts. In particular, the theoretical



model combines, in its five orientations, both history and culture in a way that does not disavow the place of suffering. Although this theoretical model is a constructed framework, it is, nevertheless, organic rather than crystalline. This creates both disadvantages and advantages in my theoretical approach. However, in adding my perspective to the growing contemporary discussions about depression I believe that it has value and originality that will challenge, stimulate, and enrich future discussions about depression.

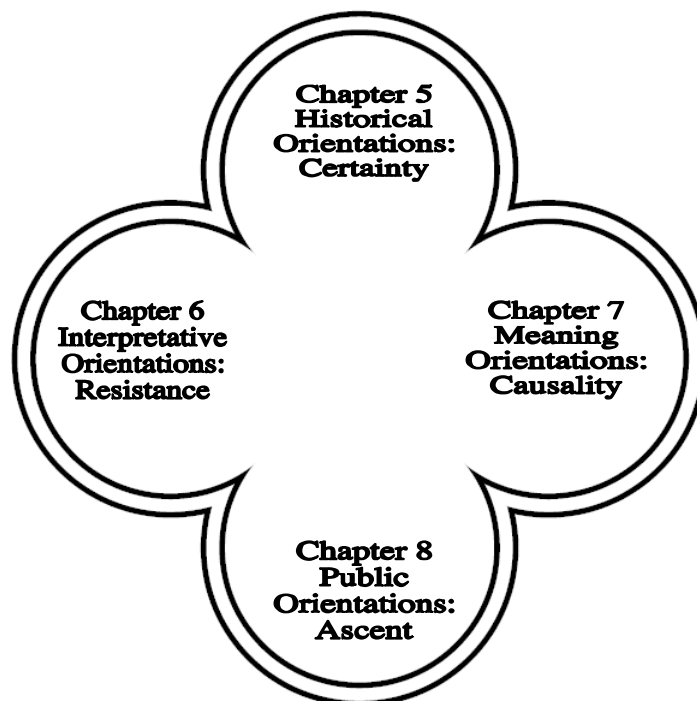
I hope this theoretical model, and its application to depression, accomplishes three things: that it is an example in some small way of the “‘sociological imagination’ at work” (Dallmayr & McCarthy 1977: 19); that it answers the ‘calls’ to “*re-think*” (Busfield 2001: 2) approaches to depression, to ‘reinvigorate’ sociological research (Nettleton 2007), and to address the problematic aspects of Western rationality (Mommensen 1987); and finally, that it be “antiquated ... [and] ‘surpassed’ and outdated” because it will raise “new ‘questions’” (Weber 1991: 138).

## Part Two

# Orientations: Examination and Discussion

There is no quality so universal in the appearance of things  
as their diversity and variety.

(Michel de Montaigne)<sup>1</sup>



**Chapter Five** examines historical antecedents influencing the contemporary Western framing of depression.

**Chapter Six** focuses on how depression is interpreted.

**Chapter Seven** considers what meanings are facilitated by such historical antecedents and interpretations.

**Chapter Eight** explores what approaches to depression are provided for the public.

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<sup>1</sup> Monatigne 1958: 344

# Chapter Five

## Historical Orientations: Certainty

**How can we know who we are if we don't know who we were?**

(Stephen Fry)<sup>1</sup>

**If men could learn from history, what lessons it might teach us! But ... the light which experience gives is a lantern on the stern, which shines only on the waves behind us!**

(Samuel Coleridge)<sup>2</sup>

**[The] past has shaped the ways in which we look at other people, the ways in which we look at the world, [and] the ways in which we react to things.**

(Margaret MacMillan)<sup>3</sup>

### 5.1 Introduction

The contemporary Western framing of depression arises from, and is influenced by, a specific historical context. In this chapter, through the application of the first part of my theoretical model (see Chapter Four: 4.2.1), I examine the depression literature to determine in what ways this literature reveals approaches to the world and to the individual that are inherited from the past. I term these approaches ‘historical orientations’. In adopting such a broad perspective I am able to situate the current Western approach to depression in its historical milieu, thereby demonstrating the presence of these historical orientations that are foundational to how depression is viewed. They reflect specific ways of looking at the world that are clearly positioned at the ‘certainty’ end of the ‘chaos / certainty’ motif of suffering discussed in Chapter

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<sup>1</sup> Fry 2006: 9

<sup>2</sup> Coleridge 1836: 147

<sup>3</sup> MacMillan 2008: 1

Three (3.4). Such an approach arises from a particular world-view concerned with certainty and the control that such certainty provides.

Discussions in this chapter proceed on the premise that history is central to examining society and focus on how the West views any aspect of the world, including depression. For this reason I have drawn on sociological literature wider than that specifically dealing with depression in order to establish the influence of historical orientations on health and illness generally that necessarily also impact on how depression is viewed. I particularly draw on Weber's ideas surrounding the religious antecedents of Western secular modernity and aspects from the Protestant ethic concerned with irrationality and the elite, Derrida's concept of logocentrism, and Levinas's approach to the relationship between Other and Same. Together these ideas furnish, I suggest, a valuable theoretical basis from which to explore the historical orientations in the contemporary Western framing of depression.

### **5.1.1 Background: View of the World**

I am interested in how the 'carriers' of history affect the present in far more profound and fundamental ways than the 'contents' of history. One of the reasons for this arises from difficulties associated with actually seeing these carriers or the potency of their influence. Analysis can therefore be problematic in trying to reveal what is essentially 'hidden' or under-recognized in the texts. Indeed, the existence of the historical orientations are fruitfully demonstrated by employing deconstruction, to point to what is hidden below the textual surface thereby revealing the 'unsaid', and a type of *via negativa*<sup>4</sup>, to point to the presence of historical orientations through negation in a process of describing what they are by what they are not. Such approaches are also useful in providing another perspective on the potency of historical orientations.

Research and discussions into the subject of depression continue to provide insight and information, both in the medical and sociological fields, but there is, however, a dearth of research into the historical phenomena that stand behind and continue to

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<sup>4</sup> See the footnote on page 105 of Chapter Four for a definition of *via negativa*.

influence this research in ways that are, at times, difficult to see. Even sociological research that specifically examines historical antecedents of the contemporary framing of depression do so in terms of *what* was thought about sadness in the past (e.g., Horwitz & Wakefield 2007), and do not explore the historical phenomena in terms of *why* depression is approached as it is in the contemporary West. By focussing on historical antecedents in this chapter I explore ‘behind the scenes’. Not only can history help us understand how we look at the world and react to it but it can also act as “a good counteractive, [a] counterbalance to making the world too simple” (MacMillan, 2008: 11). It is also only history that can teach us the lessons enabling us to understand the present: examining the past illuminates inherited characteristics that led to the contemporary world and by which it still functions.

The total world-view of secular modernity that Weber saw inherited from the West’s religious past is perhaps no more strongly evident than in the place and role of science. Through Weber’s thesis the drivers behind science, whether pure, applied, or social, are revealed to comprise belief in a total world-view and belief in mastery of the world by means of that world-view. Every aspect of society in the West, from engineering to health to sociology, is to some degree based on the foundation of science, where the world is viewed as something that can be understood and explained, and therefore mastered, controlled, and improved or corrected. Fundamentally, science dictates that there is a right way to do things and that there is a correct way to view the world, just as in the past religion dictated that there was a right way to do things and a correct way to view the world.

The scientific world-view has great advantages: planes stay airborne, depressed people receive medical care, and society is explicated. Professional standards and the regulation of the training of those wishing to enter the professions ensure that planes continue to stay in the sky, that depressed people continue to be treated, and that society continues to be studied. Furthermore, the emphasis on scientific principles also ensures that only proven techniques are used and that research proceeds according to professional (e.g., engineering, medical, or sociological) parameters. This effectively prevents unproven and untested approaches being used, although scientific approaches and techniques are inevitably “antiquated” and “surpassed” (Weber 1991: 138) as new ones develop. Nevertheless, despite such changes and

developments, those trained in the professions, the elite, still largely determine how the general public, the laity, live and conduct their lives. However, in the contemporary secular West, as Weber observed, there is not only a singularity of view, arising from monotheistic religious antecedents, but also a plurality of view, arising from polytheistic religious antecedents. This results in tensions and contestations about *which* is the correct total world-view, a situation that Weber described as an “irreconcilable” (Weber 1991: 147, 152) battle between “warring gods” (Weber 1991: 153). It is from this plurality that arises the ‘inconvenient voices’ challenging the singularity of the medical world-view concerned with certainty and evidence. In their criticisms of the medical total world-view, while not directly challenging the validity of this belief or examining its source, they reveal problems attendant to total world-views. For example, ‘inconvenient voices’ point to problems with the medical viewpoint, such as medicalization, to the difficulties medicine has of coping with ‘other’, such as alternative approaches to depression, and to issues surrounding the vexed area of evidence, such as the placebo.

Yet, the principle of a total world-view remains dominant in the West: there is a right way of viewing the world. By pursuing this ‘right way’ chaos can be controlled, the world understood, and certainty attained. Where Weber considered the Western world-view to be defined by religious antecedents, Derrida described it as logocentric in a substitution of one Rousseauistic Interpretation for another, and Levinas saw it as a Western impulse to always change the unknown (Other) into the known (Same). Whichever philosophical basis is employed, the historical orientations in the West are seen as determining a specific way of seeing the world. These are revealed in an exploration of the contemporary Western world-view; and, in my study, this endeavour is fruitfully pursued by examining its characteristics of singularity and plurality, evidence and certainty, and the elite and laity.

## 5.2 Singularity and Plurality

In medicine, that there is a ‘right way’ of viewing health and illness is an assumed *a priori* fact. Everything else proceeds from this starting point. There may be

disagreement about diagnosis, treatments, and efficacy but the premise that there is a single, correct way of viewing the world, the scientific way, is never questioned, although the type of science is often vigorously debated. Characteristically, articles in the medical journals do not identify discussions as representative of a perspective based on science. It is taken for granted that the *singularity* of the scientific world-view as *the* world-view is so obvious and accepted by all that prefacing any discussions by referring, or even alluding, to it is unnecessary. However, this singularity of view exists within a world of plurality, and the tension between how this singularity expresses itself, particularly in its relationship to the reality of plurality, gives a very ‘specific and peculiar’ tenor to the Western world-view.

Sociological research largely demonstrates the restrictive nature of the medical world-view, but fails to notice that it, too, proceeds, from a certain view of the world concerned with explanations of the ‘right way’ of viewing health and illness that is centred on social phenomena, such as gender, class, ethnicity, and poverty. That medicine is a product of society determined by a complex interplay of social characteristics and circumstances (Freund & McGuire 1995, White 2002) is only one part of the broader picture. The medical and sociological approaches furnish different perspectives on health and illness, underpinned by the same ethos of a total world-view; both, nevertheless, have value.

The singularity of medicine’s world-view betrays the presence of a logocentric / total world-view. Sociological research in the area of medicalization has contributed to an increased understanding of the processes involved in medicine’s rise to dominance in health and illness and its relationship to society (Lupton 1994, Bendelow & Williams 1995, Freund & McGuire 1995, Turner 1996, White 2002). Such processes have resulted in doctors becoming “constrained by their own world view with the result that the patient has become the object, rather than the subject” (Bakx 1991: 32). Medicalization de-socializes illness and disease so the social is obscured at the same time as it then explains the social in biological terms (Filc 2004), even though there “is no position ‘outside’ society (or outside one’s own body for that matter) from which to study biology” (Broom 2001: 6). However, medicalization is as much driven by doctors as by patients and the health system itself (Sleath & Shih 2003, Shaw & Woodward 2004b), and doctors themselves are increasingly concerned

about the medicalization process and turning the public into the “‘worried well’” (Williams 2001: 143). In addition, the complex interrelationship between wider cultural influences, such as gendering and pharmaceutical advertising to doctors (Curry & O’Brien 2006) and language and popular notions of depression (Metzl & Angel 2004), produce a complex nexus indicating that medicalization, while indicative of medicine’s total world-view, is neither linear nor singular.

Medicalization is a characteristic of a centred world-view (Derrida) or a total world-view (Weber). Indeed, it could be viewed as a ‘symptom’, because such a symptom cannot exist without a world-view intent on extending medicine’s power and authority into all aspects of life. As previously religion exerted control over every aspect of life, medicine now exerts control over increasing areas of human life. However, medicalization is not clear-cut. There is frequently considerable disagreement about the creation of new diseases, often under pressure from patients, for which there are no cures (Cooper 1997) and conversely some patients find themselves in a position where medicine fails to explain their ailments (Nettleton 2006). Nevertheless, this ‘symptom’ (medicalization) can be seen in many, if not all, areas of medicine ranging from menopause (Ballard *et al.* 2001), to sleep (Moreira 2006), to death and dying (Timmermans 2005), to anxiety (Schneier 2006), to shyness (S. Scott 2005, 2006, Lane 2007), to sadness (Pilgrim & Bentall 1999, Shaw & Woodward 2004b, Bell 2005), and to the belief that genetics will one day provide answers to the current puzzles of illness (Conrad 1999). Genetics, moreover, leads to specific issues of medicalization. For example, foetal screening for genetic abnormalities, although providing valuable information, leads to ethical dilemmas regarding termination of fetuses deemed to be disabled (Remennick 2006, Williams 2006). While specific genes for depression have not yet been isolated (Insel & Charney 2003, Ebmeier *et al.* 2006), genetic research into depression (Barondes 2003, Bennett 2007) runs the risk of becoming another form of medicalization (Melzer & Zimmern 2002). The internet has, against some opinion, maintained the dominance of the medical position on health and illness in promulgating medical perspectives (Nettleton *et al.* 2005), and hence the process of medicalization.

Depression is particularly interesting because it has no biological markers. Despite advances and research in neuroscience (Davidson *et al.* 2002, Joyce & Paykel 2006,



2007, Meyer *et al.* 2006, Norman 2006) and genetics (Bennett 2007), the causes of depression and the action of drug treatments are yet to be fully understood (Ebmeier *et al.* 2006). Nevertheless, considerable emphasis in depression research continues to focus on the validity and use of science and scientific approaches. These include: the development of an algorithm to predict episodes of depression (King *et al.* 2008), the use of taxometric procedures for studying depression (Slade 2007), the use of neurochemistry in analysing depression mechanisms (Bremner *et al.* 2003), and the development of a taxonomy for general practice management of depression (Clarke *et al.* 2008). While historically psychiatry was always interested in the scientific basis of the biological approach to mental illness, there has been an increase in the diagnostic categories of milder forms of depression (Moncrieff & Crawford 2001) as the medicalization of unhappiness has extended (Horwitz & Wakefield 2005).

There is concern within the medical profession that the biological emphasis over social and psychological psychiatry has detrimentally affected psychiatric approaches to depression (Double 2002, Dowrick 2004, Blazer 2005), and that sociological as well as medical research into the medicalization of unhappiness as depression would be beneficial (Middleton *et al.* 2005). Nevertheless, diagnostic guidelines, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, exercise enormous influence and control. As a tool of medicalization, the different editions of the *DSM* highlight the medicalization process whereby diagnostic criteria reflect the dominance of the biological explanation of mental illness over the psychoanalytical, with major depression being a very recent new diagnostic label (McPherson & Armstrong 2006). Indeed, the biological dominance of psychiatry has resulted in a “480 percent increase in the number of psychiatric abnormalities over fifty years”, which “cannot result solely from dispassionate scientific discovery” (Karp 2007: 212). Despite the increasing plethora of diagnostic categories that plague psychiatry, however, it is still suggested that treatment-resistant depression may need to be considered a separate category (Wijeratne & Sachdev 2008).

Psychiatric diagnostic manuals continue to increasingly categorize mental illnesses in a process that can be viewed as pathologizing the human condition (S. Scott 2006), but focussing too narrowly on the experience of the person can also have

negative implications for those suffering from severe mental disorders (Mulvaney 2000). The process of medicalization, as a symptom of the medical-scientific total world-view, both pathologizes and restricts understanding but also provides labels that allow a person to access assistance from the health system. For example, women with post-natal depression are able to access medical help because of this medical label, but, conversely this very label focuses understanding at the individual and biological levels that prevent, curtail, or restrict wider social understandings and framings (Everingham *et al.* 2006).

These parallel and oppositional results of medicalization are particularly evident when psychiatric diagnostic manuals are used in different countries and cultures. In Latvia the idea of a cure for conditions like depression was considered a foreign concept because a different ethos operated under the Soviet medical system to that in the Western medical system, and it was only after the fall of communism that there was a concerted effort to become more westernised in the belief that Western psychiatry was more scientific and therefore better able to understand human distress (Skultans 2003). The world-view inherent in the Western medical approach to health and illness is highlighted even more clearly in non-Western cultures. For example, in Egypt the *DSM* guidelines have to be not only translated but also reinterpreted into underlying Egyptian concepts of the world before they can be used (Coker 2003). Similarly, in an Asian context the Western assumptions of depression as a disease are revealed to be culturally bound and constructed (Burr & Chapman 2004, Inaba *et al.* 2005, Karasz 2005).

Ethnicity affects not only how people understand and experience their depression as social in origin and solution (Lackey 2008) but also how they seek help (Mallinson & Popay 2007) and in the links made between somatization and depression (Keyes & Ryff 2003, Kleinman 2004). What *within* a culture is not visible becomes visible in its interactions *with other* cultures: the *a priori* nature of a world-view is revealed as a particular orientation rooted in history and culture. Hence, what within Western medicine seems to be, *a priori*, the correct world-view of depression, because it is based on science, is revealed to be directly reflective of a specific Western way of seeing the world inherited from its past.

The West does attempt, nevertheless, to recognize and facilitate cultural difference. Negotiating an approach between differing world-views can take, however, bizarre medical forms: for example, psychiatric explanations of cultural psychological differences are used to argue for reduced sentences in cases of murder committed by non-Western immigrants (Reddy 2002). In such cases, the pathologizing of cultural difference reflects the scientific basis of the medical total world-view that can only respond to cultural difference through scientific labels and explanations. It also reflects an assumption on the part of the medical profession, and other social institutions and professions (*e.g.*, the legal system and lawyers), that such medical perspectives, which have spread far beyond its medical parameters, are *the* correct way of approaching such cultural difference due to differing world-views.

The assumptive nature of medicine's total world-view is also revealed in sociological research that examines depression in terms of societal and cultural factors. For example, the relationships between depression and gender (Nazroo *et al.* 1998, Bracke 2000, Griffin *et al.* 2002), between depression / mental illness and class / marginalization (Olstead 2002, Lester & Tritter 2005, Lincoln 2006), between depression, homelessness, and social support (Irwin *et al.* 2008), and between depression, poverty, and gender (Meertens *et al.* 2003) all point to the existence of certain assumptions. That is, sociological research and discussion often begin from a complex position of two interconnected assumptions: that medicine's largely biological view of depression is incomplete or in error in some way and needs correction, adaptation, extension, or redirection and that medicine's view of depression can be transformed into *the* correct world-view of depression through sociological insight and knowledge. These assumptions indicate both the presence of differing ideas about depression at the same time as belief in the existence of a total world-view of depression. There is both reaction (against the content of the medical paradigm of depression) and acceptance (of the form of the medical total world-view of depression).

In the past, the West's religions, due to their total world-view (Weber) / religiously-centred logocentric view of the world (Derrida), expressed a fundamental belief in the ability of theological doctrines to explain and control all things. Today, modern medicine also expresses a fundamental belief in its scientific doctrines to explain and

control (treat) illness, or will do so in the future when science has further progressed. In this way medicine is able to control the body, “keeping it from subsiding into the chaos and disorder threatened by illness and disease” (Lupton 1994: 87). Medicine, because it is centred on science, tends to foster an approach to health and illness solely within narrow scientific parameters, where “disease is reconfigured only as an alteration in biological structure or functioning” (Kleinman 1988: 5-6).

This reflects an interesting coexistence of two factors that demonstrate the presence of medicine’s total world-view: one concerns the belief in science as *the* way of viewing the world and the other concerns the approach in science that is based on doubt, not certainty. Science is not a series of ‘discovered facts’ but a series of working hypotheses, which requires change following new discoveries:

Science depends, not on the inductive accumulation of proofs, but on the methodological principle of doubt. No matter how cherished, and apparently well established, a given scientific tenet might be, it is open to revision – or might have to be discarded altogether – in the light of new ideas or findings. (Giddens 1991: 21)

However, because secular modernity inherited a total world-view from its religious past requiring that its new belief system (science) provide the only and universally valid way of seeing the world means that science, while based on working hypotheses and doubt, is *also* required to provide the certainty of a total world-view.

Another useful way of understanding medicine’s scientific total world-view is to summarize what these discussions have indicated such a world-view is not. This reflective process, by way of a *via negativa*, aids in isolating what actually constitutes medicine’s world-view, rather than what appears to constitute this world-view. Such a process of negation proceeds by describing what the total world-view is not to help reveal what it is, or at least might reasonably be. Through a *via negativa* the world-view of medicine is seen to be *not* completely homogeneous, totally hegemonic, entirely consensual, always internally consistent, thoroughly controlling, nor comprehensively power seeking. Taken as a starting point, these negations reveal what medicine’s total world-view *is*: it is a way of viewing the world based on a singularity of perspective within a plurality of opinion with a strong tendency to be

what it, nevertheless, fails to be. It is a world-view that, because of its religious antecedents, has been impelled to operate as a total world-view, providing singularity and certainty. Consequently, medicine proceeds in the belief that its scientific foundation is the only valid way of approaching health and illness, while, at the same time, this very approach is itself grounded in doubt, rather than certainty. It is this clash between expectation and reality that leads to the problematic position of functioning as a total world-view when this is actually impossible.

In addition, secular modernity is characterized by pluralism, which further exacerbates the problematic emphasis on singularity, and the certainty of this singularity. It is because of the expectation that science will operate as religion once did that it is expected to be what it cannot be. The tension between expectation of a total world-view and the characteristics of science are irreconcilable. This places doctors in a difficult position. They “are positioned simultaneously as powerful and powerless” because the certainty of the medical model “that depicts depression as an objectively measurable condition” fails to address the complexities and realities of clinical practice where the doctors are constrained by the clash between the certainties of the medical model and the uncertainties they discover in practice (Thomas-MacLean & Stoppard 2004: 288). Doctors also face tensions between a focus on the health issues of their individual patients and on the general population as a whole that likewise lead to medical uncertainty (Griffiths *et al.* 2006).

This twin imperative (expectation of a total world-view *and* the hypothetical nature of science) both drives medical dominance and causes contestation in opinion about diagnosis and treatment. There is in medicine both the singularity of a total world-view based on science and at the same time often considerable disagreement about how best to enact that total world-view and about how to deal with ‘other’ world-views. The latter are particularly symptomatic of the plurality of opinion that Weber saw characterising modern secular modernity, representing the re-emergence of the pluralism characteristic of indigenous religions. However, instead of coexistence between these pluralities there is a vying for dominance. Historically, the dominance of medicine over other forms of healing in the modern West is a product of social history, economics, and politics (Freund & McGuire 1995).

The relationship between medicine and complementary and alternative medicine (CAM) reveals both the way that medicine, as the dominant total world-view, deals with these 'other' world-views, the pluralism in the modern world, and what eventuates when such different world-views meet. It was assumed that other forms of medicine would disappear with the supremacy of modern scientific-based medicine. However, this did not occur (Bakx 1991) and interest in, and use of, CAM has proliferated in recent decades (Leiser 2003, Barry 2006), despite the complex, mixed, and changing relationship between CAM and evidence-based medicine (Willis & White 2004). However, even in growth areas, such as naturopathic medicine, issues of gaining legitimacy, internal consistency, and a 'place' within the regulated medical profession predominate future developments and societal positioning (Verhoef *et al.* 2006). Medicine exerts its dominance over CAM by pointing to lack of proven scientific efficacy. Yet, in some cases it also employs homœopathic medicine as a means of avoiding the iatrogenic effects of pharmaceutical treatments, even though it is antithetical to CAM (May & Sirur 1998), and accommodates practitioners of CAM, even though their dominance over CAM is maintained by demarcation of boundaries between doctors and the practitioners of CAM (Mizrachi *et al.* 2005).

There is a continual negotiation of position and boundaries between medicine and what it perceives as 'other', although medicine always maintains the dominant position. At the same time as it resists alternatives, modern Western medicine also employs aspects of these alternatives, and as CAM resists 'orthodox' medicine, it also seeks legitimacy from it (Goldner 2004). However, in achieving such legitimacy, CAM has often been required to radically change, bringing it in line with the medical world-view based on science, something welcomed by some practitioners and not by others (Barry 2006, Villanueva-Russell 2005). This complex relationship between medicine and alternative approaches to health and illness result in CAM simultaneously de-medicalizing and re-medicalizing (Williams 2001). The ways in which CAM (as an example of Other) is only accepted by medicine (as an example of Same) if it has changed according to medical parameters, sometimes beyond recognition from its original parameters, is an example of the Levinasian impetus of Same to always change Other into Same in order to control it.

The ‘Rapid Responses’ to a paper reported in the *BMJ* examining an alternative approach to depression treatment using dolphins (Antonioli & Reveley 2005) reveals both the problems attendant to a total world-view and the doubts within medicine of its own perspective. To conduct their research within scientific parameters the researchers used a randomized control trial (RCT). While criticisms of any research often point to perceived flaws or shortcomings in trials, the presence of sarcasm has transformed some of the responses from critical evaluation to emotive reaction. For example, Reimer writes, “Christmas has come early this year, because BMJ usually reserve the unprobable and hilarious papers for its x-mas edition” (Rapid Responses to Antonioli & Reveley 2005: 2). Such sarcasm rather beautifully (and ‘hilariously’) crystallizes the problems of a total world-view. Anything outside the world-view is simply ‘outside’, deserving of no consideration or respect and sometimes nothing more than serving as the butt of a joke.

Other responses that warmly or cautiously welcomed this research by Antonioli and Reveley (2005) reveal that the total world-view of medicine does not preclude other possibilities, so long as these approaches are positioned ‘within’ a medical framework because alternative approaches must be validated by science. Alternative approaches for the treatment of depression are variously received by medicine: as requiring further study, as totally lacking in efficacy, or as efficacious. This variety of opinion indicates clearly that medicine is not an homogeneous entity and that consensus of opinion about depression treatments is lacking even as the consensus regarding the total world-view of medicine is maintained.

Medicine also considers that if science cannot fully explain or control illness now it will do so in the future. The vast majority of the medical papers on depression either refer to or call for more research (*e.g.*, Davidson *et al.* 2002, Insel & Charney 2003, Mann 2005, Ebmeier *et al.* 2006, Norman 2006) in the belief that this will provide the answers in the future. Even those that do call for re-evaluation (Blazer 2005) still proceed on the basis that securing the ‘right’ response will solve, or help to solve, the problem of depression and improve current approaches to depression. However, still present is the belief that the correct view of the world will furnish certainty. Yet, even with advances in neuroscience, depression remains a largely unquantifiable condition straddling both body and mind, and medicine’s *a priori* position of

scientific truth and certainty results in positive emotions aligned with health and negative emotions pathologized as illness (Williams 2000b). Moreover, the emphasis on the absolute validity of science as the total world-view in the West is given further impetus and cogency by characteristics Weber identified as resulting from the Protestant ethic: namely, the rejection of irrationality and the emphasis on rationality. The combination of a total world-view based on science and the Protestant ethic's imperative to reject all forms of irrationality and adopt rationality in all matters has resulted in a potent unseen force in Western secular modernity. Such historical orientations do not merely define the contours of medicine they impel the direction it takes, which in turn influences how it responds to alternative views.

It could be argued that, given internal disagreement and division and even war, neither Judaism nor Christianity successfully achieved the reality of a total world-view in providing world-mastery and certainty in all things. Nevertheless, what did unquestionably exist was a *belief* in the possibility of the existence of a total world-view and society functioned in this belief. Weber considered the modern Western secular total world-view to have been transferred directly from the West's Judaic-Christian past, minus the religious content, and I suggest that it is the belief in the possibility of the existence of a total world-view that not only drives and underpins modern science, and therefore medicine, but that defines its very nature.

Medicine is believed to be the total world-view on health and illness, not because it is superior and true, compared to other health systems, but because it achieved dominance and therefore expects to function as a total world-view, despite the evidence of a plurality of ideas and opinions. Pilgrim (2007) explores why psychiatric diagnosis, in areas such as depression, has survived despite criticism, instability of diagnosis, and difference of opinion. I suggest that it is the force of the medical total world-view as it operates in psychiatry that drives the survival of psychiatric diagnosis. Historical orientations, because there are characteristically *a priori* in nature, operate in society in profoundly influential ways that not only remain largely hidden but confound and complicate all discussions because such discussions are generally concerned with the 'what' of any topic rather than the 'why' that stands silently behind all of society's 'whats'.



From a Weberian perspective, science is believed to be a total world-view because religion operated as a total world-view. This results in medicine functioning as the secular world's total world-view in the area of health and illness. Other value systems, such as complementary and alternative medicine or sociological approaches concerned with societal factors (poverty, employment, *et cetera*), can be seen as representative of a re-emerging plurality. These alternative world-views are not only in conflict with the dominant world-view of medicine but are also often internally in conflict, just as medicine is plagued by internal conflict. Such pluralism, in the form of 'inconvenient voices', is marked by often irreconcilable differences of opinion. These 'inconvenient voices' help reveal the existence of a total world-view, even though they do not necessarily challenge the belief in a total world-view. While the medical approach to depression is dominant in the contemporary West, the ghost of polytheism, in the form of disagreements and alternative approaches and understandings, undermines its dominance, curtailing the complete imposition of its total ('monotheistic') world-view. In a Derridean sense, it is the exclusive nature of the logocentric world-view that creates discord with anything outside such a centred world. Science is the latest logocentric world-view and, as a Rousseauistic Interpretation, is based on a self-referential centre that is entirely self-validating. The problematic nature of a total / logocentric world-view trying to control or dismiss plurality can also be seen in the Western preoccupation to always take that which is outside (Other) and subsume it under Same in order to control it. Nevertheless, both medicine and sociology provide valuable and growing perspectives on depression, even as they are constrained and restricted by a total world-view and even as they their views are buffeted by a plurality of approaches to, and understandings of, depression.

### **5.3 Evidence and Certainty**

One aspect of modern Western medicine that clearly demonstrates, perhaps more than any other, both the presence of a total world-view and the belief in world-mastery is evidence-based medicine (EBM). As "the conscientious, explicit, and judicious use of current best evidence", it has become the "gold standard" of

modern medicine (Sackett *et al.* 1996: 71, 72), and is the source of power behind medicalization (File 2004). Modern Western medicine proceeds in the belief that EBM furnishes the best outcomes for patient treatment, and this approach controls research and development. While EBM has contributed to the control and monitoring of the safest and best treatments, the focus on science as the only arbitrator restricts the possibilities and contributes to differences of opinion, even when they arise from within the scientific paradigm. EBM is concerned with evidence and certainty, but it is these characteristics that lead to all the disagreement and criticism.

EBM is founded on science and is not neutral: it could be considered “the latest expression of ‘scientism’” in its belief that its evidence is objectively acquired (Goldenberg 2006: 2630). Further, science is criticized from the sociological perspective for failing to acknowledge that there “is no such thing as The Evidence, just competing bodies of evidence” (Barry 2006: 2648), that evidence always emerges from social processes (Hyde 2000), and that evidence is socially and politically constructed (Barry 2006). There is a failure in medicine to recognize, or fully recognize, that “the production of scientific evidence is a social as well as a scientific process” (Barry 2006: 2648). While EBM is based on the certainty of its scientific parameters, it does not always respond by rejection of criticisms and alternatives but also by a process of incorporation and assimilation (Lambert 2006), whereby medicine integrates elements of CAM (Willis & White 2004). Historically the power base of medicine “stems from its claim to successful treatment through adherence to scientific orthodoxy”, but when it failed to successfully undermine alternative medicine “it incorporated their methods” (Bakx 1991: 22).

As with medicalization generally, EBM is not an homogenous entity intent on absolute domination and control but is “an indeterminate and malleable range of techniques and practices unified ... by the pursuit of a new approach to medical knowledge and authority” (Lambert 2006: 2639). Thus, while EBM may be described as the latest incarnation of medical scientism, proceeding according to rigorous science and with the use of increasingly sophisticated technologies and diagnostic systems, it may also be described as a continually metamorphosing nexus of science, the doctor, and the patient. Medicine places great emphasis on the value of evidence and the certainty it can provide in diagnosis and treatment, but emphasis

is also placed on the need to combine EBM with clinical observation and experience (*e.g.*, Sackett *et al.* 1996, Kendrick *et al.* 2008). EBM could well be characterized as an unlikely, if at times incompatible, combination of outright rejection and circuitous assimilation.

Sociological research reveals problems inherent in EBM, pointing to fundamental contestations and difficulties surrounding the nature of evidence within medicine and concerns over its impact on medical care (White & Willis 2002, Mykhalovskiy & Weir 2004, Goldenberg 2006, Lambert 2006). Across various medical fields, ranging from cervical cancer (Hyde 2000) to myalgic encephalomyelitis (Cooper 1997) to obesity (Chang & Christakis 2002) to attention deficit hyperactivity disorder (Rafalovich 2005) to depression (Horwitz & Wakefield 2007), there is disagreement and / or changes of opinion about what the evidence actually indicates. Medical opinion also raises doubts and concerns about the framing of EBM, particularly concerning the trials by which drugs are judged. EBM is a classic example of how the Derridean Rousseauistic Interpretation functions because its validity is entirely self-referential. However, there is much concern within medicine that perhaps this tightly defined world-view is too exclusively focused on science and biology (Summerfield 2006a, 2006b), missing some important aspects and some other possibilities, thereby complicating the evidence provided by EBM. Questions about EBM, and about the certainty it is claimed to furnish, have been raised from within the medical profession, particularly concerning the validity of the randomized controlled trial and the problems of the placebo effect (Dewhurst 2004, Moncrieff & Kirsch 2005).

There is agreement in both medicine and sociology that there are problems with EBM. While opinions vary greatly as to what these problems are, what causes these problems, and how best to fix these problems, ultimately there is a single problem, I suggest, behind all these identified problems: the belief in a total world-view and the associated fixation on the relationship between evidence and certainty. It is this relationship, for example, that contributes to the difficulties and disagreements surrounding EBM in psychological and psychotherapeutic treatments of mental illness, including depression, compared to antidepressant treatments (Holmes 2002; see also critical responses to this paper, *e.g.*, Blenkiron, Darnley, Sensky & Scott,

and Tonks). Both criticism and support of EBM often centre around issues of how the evidence is collected, judged, and interpreted, rather than on examination of what fuels these discussions and criticisms. The problem may not be “so much with evidence based medicine as with its users, who find it a useful but sometimes dangerous rock of certainty in an uncertain world” (Dewhurst 2004: 963). Nevertheless, in medicine there is considerable emphasis placed on improving the evidence base (Kendrick 2000, Kendrick *et al.* 2008) and on the continuing value of EBM, despite problems, concerns, and disagreements over the certainty it purports to provide.

One of the most vexed and divisive problems in EBM, for both sociology and medicine, is the placebo. The placebo effect is an extremely complex and complicated matter from whatever aspect or discipline it is viewed (Harrington 1997), and has a lengthy and contentious history (Wampold *et al.* 2005). Although advancements in clinical practice are dependent on future placebo research (Price *et al.* 2008), differences of opinion are rife concerning the place of the placebo in depression research (Scott 2000, Parker 2004b, Moncrieff & Kirsch 2005). Studies have shown that in the treatment of depression selective serotonin reuptake inhibitors (SSRIs) are no more efficacious than placebos, except in cases of severe depression (Mayor 2008), or, alternatively, are no more efficacious than placebos, including cases of severe depression (Moncrieff 2005, Moncrieff & Kirsch 2005). The placebo is considered to be of major scientific importance and is viewed as being essential to the trial process, providing necessary complexity that may lead to clues about the healing process and alternative therapies for depression (Kupfer & Frank 2002), but there are concerns about the ethical use of placebos in antidepressant trials (Walsh *et al.* 2002). However, it is also considered that the apparent similarity between placebo and SSRIs is due to poor trial design that confounds the results (Geddes & Cipriani 2004, Parker 2004b). In contrast, other opinion considers consumers themselves should be involved in trial design as they could benefit recruitment and assessment of trial outcomes (Hatcher 2005).

Although the placebo effect is potentially problematic for EBM, the causes of these problems are not related to evidence and how it is collected and interpreted (this is what the literature is primarily concerned with, however) but to the total world-view

of medicine that *requires* EBM provide evidence and certainty. The problems raised by the placebo effect are not indicative that EBM is flawed in the search for evidence and certainty. Rather, they indicate that medicine's need for clear scientific evidence and certainty exists in a world that is characterized by plurality of view, not singularity.

The problems over evidence, and the certainty of what that evidence proves, is particularly clear in the encounter between EBM and CAM (Freund & McGuire 1995, Willis & White 2004, Barry 2006) and traditional healing systems such as Chinese medicine (Quah 2003). In medicine, EBM is considered crucial for examining alternative approaches to depression. Most studies have found that such alternatives for depression treatment are not well supported by evidence as are standard medical treatments for depression, but that some do warrant, nevertheless, further research (Jorm *et al.* 2002, 2006c). Five large meta-analyses of homœopathy trials indicate that homœopathic medicine has no statistical efficacy over placebo, but may still have value as a placebo (Goldacre 2007). However, there are concerns, revealing the sense of protection medicine exhibits towards its scientific parameters, that homœopaths “can misrepresent scientific evidence” to the public and so undermine EBM (Goldacre 2007:1673). Samarasekera (2007) reports on the campaigns against homœopaths in the United Kingdom that were undertaken in an effort to publicise the scientific implausibility of homœopathy as a treatment. Such responses indicate quite clearly, I suggest, the exclusive and centred nature of the scientific evidence comprising medicine's total world-view (stemming from the Weberian monotheistic total world-view) or logocentric world-view (stemming from the centred nature of the Derridean Rousseauistic Interpretation) and the rejection of irrationality and concomitant embracing of rationality in all things (stemming from the Weberian Protestant ethic).

According to medicine, alternative approaches to depression have evidential problems of some sort. For example, some fail to achieve scientific validation, such as the use of bibliotherapy for depression (Anderson *et al.* 2005), or are discounted due to poor trial design, such as exercise for the management of depression (Lawlor & Hopker 2001). In other cases, opinion can differ substantially. For example,

evidence for the use of hypericum<sup>5</sup> as an alternative treatment for depression varies from finding it efficacious (Philipp *et al.* 1999, Szegedi *et al.* 2005) to a lack of any evidence for its use (Shelton *et al.* 2001, Hypericum Depression Trial Study Group 2002, Kupfer & Frank 2002) to evidence not being sufficiently established (Linde & Berner 1999). Even opinion that welcomes studies showing efficacy of hypericum advise against its use in treatment of major depression because the evidence is considered to be contradictory and confusing (Williams & Holsinger 2005). However, as with homœopathy, hypericum is considered to have a placebo effect in the treatment of depression (Kupfer & Frank 2002). Similarly, although some studies have shown exercise reduces symptoms of depression, a recent study determined that while exercise was positively related to reduced symptoms of depression no causal effect was found (De Moor *et al.* 2008).

The place of spirituality and religion in health (McGuire & Kantor 1987, McGuire 1990, Williams & Sternthal 2007), its value in coping with mental illness (Culliford 2002a, Wilding 2007), and its application in clinical practice (Culliford 2002b, D’Souza 2007) are examples of other alternative approaches that have been considered for some time. However, while spirituality is an area for which more research is repeatedly called for, there seems little real progress and it also elicits disagreement (see, for example, Peach 2003a, 2003b and Koenig 2003a, 2003b, Gijssbers 2003). The use of prayer presents some interesting problems of evidence that require researchers to accept that “some aspects of prayer may not be transparent to scientific investigation and may go beyond the reach of science”; however, while prayer may offer some benefits, particularly as a coping mechanism, it is considered inadvisable for use as a treatment option (Jantos & Kiat 2007: S53). Interestingly, as with homœopathy and hypericum, prayer in medicine is also considered to potentially have a placebo effect that may be useful in treatment (Jantos & Kiat 2007).

There seems to be a consensus, arrived at by proof of evidence based on a scientific viewpoint, that alternative approaches to depression may well have positive effects but do not qualify as treatment options. Interestingly, though, Parker and Crawford

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<sup>5</sup> Hypericum is the herb St. John’s Wort.

(2007: 37), from research about patient views on effectiveness of antidepressants and alternative therapies, concluded that rather than merely considering the efficacy of alternative therapies, “it might be important to determine the circumstances ... that are associated with their judged utility”.

I find it fascinatingly revealing of the historical orientations driving modern medicine that, in trying to both validate the value of EBM and deal with the evidential problems raised by the placebo effect and CAM, the solution by medicine tends to be to view CAM as positive and efficacious *only* in that these alternatives function *as* a placebo. This is perhaps the best outcome for a total world-view operating within a pluralistic world: medicine does not entirely reject the ‘other’, but only accepts it in so far as the scientific evidence base remains in tact and the scientific certainty of medicine is upheld. This directly reflects the problem Weber identified in secular modernity where a total world-view that expects to master the world exists in a world of evident plurality that cannot be either got rid of or ignored and where, stemming from the Protestant ethic, irrationality is totally rejected at the same time as rationality is totally embraced.

Another aspect of EBM that is of great concern to many and widely considered problematic is the role of pharmaceutical companies, particularly the influence they wield on doctors, research, and the public (Healy 1997, 2004, Moynihan *et al.* 2002, Geddes & Cipriani 2004, Horwitz & Wakefield 2005, Karp 2007, Moynihan 2008, Rice 2008). Full disclosure of trial results, not only the positive results, is considered necessary because of risks, adverse effects, and the possible negative impact on treatment arising from the lack of full details (Ramchandani 2004, Moncrieff & Kirsch 2005, Turner & Rosenthal 2008, Turner *et al.* 2008, Lenzer & Brownlee 2008). As with so many aspects of medicine, however, there is considerable disagreement about interpretation of trial data, about what the problems are, and about how to remedy them (for example, see Turner *et al.* 2008 and letters of response to this study by de Jonge & Bockting 2008, Schoones 2008, Ninan *et al.* 2008, and reply by Turner & Tell 2008). Dewhurst (2004: 963) discloses that, from his own experiences as a pharmaceutical physician in the pharmaceutical industry, many negative studies were “never published”. Similarly, Moncrieff and Kirsch (2005: 156) report on evidence showing “that trials of antidepressants with negative

results are less likely to be published than those with positive results and that, within published trials, negative outcomes may not be presented”.

There are also “serious concerns about bias in drug company sponsored trials and the effectiveness of the regulatory agencies in ensuring trial integrity” (Ellis *et al.* 2004a: 892). Changes to the registration of clinical trials are viewed as necessary to ensure full disclosure of trial results (Wood 2009). The increasing location of trials in third-world countries raises concerns about the reliability of trial results due to regulatory differences between countries and about issues of social ecology and genetic make-up in the trial populations compared to the user populations (Glickman *et al.* 2009). In addition, the trials themselves, which often exclude women because the female body is not static and could adversely affect results and analysis, are not representative of the general population (Broom 2001, Goldenberg 2006). Recent meta-analyses and clinical studies have also demonstrated a clear link between funding source and research outcome (De Vries & Lemmens 2006). Moreover, apart from the serious problem of industry bias in the medical journals, where articles are ghost-written on behalf of the pharmaceutical companies (Healy 1997, De Vries & Lemmens 2006), industry-funded ghost-written articles have been shown to have a higher impact factor than non-industry-funded articles (De Vries & Lemmens 2006). There is also concern about the lack of full disclosure of industry payments and gifts to physicians (Steinbrook 2008, 2009) and industry influence on doctors in terms of treatment options (Campbell 2007).

The relationship between doctors and the pharmaceutical industry, as well as with government and the public, is a highly complex and convoluted problem, socially, economically, and politically, which can powerfully and adversely affect the patient (Medawar & Hardon 2004). A realist sociological approach is one suggestion as a more beneficial means of studying the pharmaceutical industry and improving public health over industry interests (Abraham 2008). In addition to influences exerted by the pharmaceutical industry is the existence of other key players and factors that all contribute to an interrelated confluence of medicine, drugs, and evidence (Williams *et al.* 2008). These include: the media, where health and illness information become entertainment as well as news (Seale 2003), where lay beliefs of madness underpin media portrayals of mental illness (Nairn 2007), and where depression is



promulgated as individual pathology requiring medical intervention (Rowe *et al.* 2003); public health, where health outcomes can be at odds with epidemiological evidence (Worthman & Kohrt 2005), and where the growing corporatization of health care provision impacts on the delivery of medical care (White 2001); globalization, where a combination of political, social and economic factors impact on and influence people's perceptions, attitudes and expectations (Walker 2007); and social health movements, where individuals have been shown to influence research directions (Brown & Zavestoski 2000, Goldner 2004, Hess 2004, Allsop *et al.* 2006). To ignore the role of other powerful influences in any area of medicine, including depression, is to assign a greater dominance to medicine and a greater homogeneity and control to EBM than, in reality, exists.

An interesting study concerning how SSRIs were marketed in Argentina (Lakoff 2004) provides a fascinating perspective on the place of evidence and the relationship between pharmaceutical companies, doctors, and regulatory organizations. In Argentina there are no regulatory bodies requiring diagnostic criteria for drug certification and use or for insurance claims. An increase in the use of SSRIs, without a concomitant increase in the rise of depression diagnostic rates, revealed they were used not to treat chemical imbalances in the brain but to help with "insecurity and vulnerability" caused by recent upheavals in the country (Lakoff 2004: 266). This rather undermines, or substantially challenges, the evidence base in medicine purporting that antidepressants effectively treat depression because they correct the imbalances in brain chemistry causing depression.

EBM is possibly the most important characteristic of modern medicine's total world-view. The medical view of the world displays a tight focus on scientific evidence and the certainty that such evidence furnishes for diagnosis and treatment. The validity of this evidence is believed to arise from correctly operated trials that measure and judge the available evidence according to scientific parameters. However, there is considerable difference of opinion about how this evidence is actually gathered, what this evidence actually measures, and what this evidence actually indicates. Research in both medicine and sociology amply reveals the problems associated with the evidential base of medicine, particularly in its relationship to CAM. It is for these reasons that "EBM is a tool *of* medicine, but also a tool used *against* medicine"

(Villanueva-Russell 2005: 558). Both medicine and sociology oscillate between these polarities in the quest for certainty concerning the evidential basis of medicine.

The belief that evidence will provide certainty of approach stems directly from the total world-view of medicine. Medicine's presuppositions concerning the evidence and certainty underpinning its "task of ... diminishing suffering" cannot be scientifically proved, only "*interpreted*" with reference to the scientific total world-view (Weber 1991: 143-144). However, just as belief in a total world-view has been shown to be fraught with difficulties and complexities due to the singularity of this belief and the evident plurality of the world so too the evidential base and certainty of medicine suffers the same difficulties. Indeed, the paradoxical situation in which increased control over health and illness facilitated by medicine has resulted in greater uncertainty (Williams & Bendelow 1998) reflects not only confusion over what is normal or abnormal but the difficulties attendant to the very tensions between singularity and plurality and between evidence and certainty. In addition, because evidence is based on science, which is characterized by doubt and hypothesis, the notion that science can provide clear-cut evidence and certainty in terms of a total world-view is almost antithetical. It is not that science cannot provide evidence and certainty of a type, but that, by its very nature, it cannot provide them to sustain a total world-view. An inchoate awareness of this problematic, I suggest, is reflected in sociological literature calling for a wider critique and analysis of EBM, rather than only criticism, (*e.g.*, Mykhalovskiy & Weir 2004, Lambert 2006), and in medical literature promoting alternative approaches (Antonioli & Reveley 2005) and raising concerns about EBM (Dewhurst 2004).

A useful approach that reveals the complex and complicated nature of evidence and the certainty it purports to provide is to deconstruct the use of the word 'evidence' itself, while being mindful at the same time of the certainty that this evidence is believed to bestow. By utilizing this Derridean approach, another perspective on the problems attendant to the total world-view of medicine founded on science can be explored. The word 'evidence' appears throughout the medical literature and is concerned with both proving the value of EBM or pointing to problems and offering solutions. Nevertheless, the emphasis is always on evidence providing the certainty of correct knowledge and understanding. However, even a cursory examination of its

use and meaning raises, and helps substantiate, the very problems revealed in preceding discussions. Its use immediately suggests such questions as: ‘Whose evidence?’, ‘Evidence according to what basis?’, ‘Evidence by what standards?’, ‘Who benefits from this evidence and who is disadvantaged?’, ‘What does the evidence represent?’, ‘What does the evidence indicate and mean?’, and so on. These questions help focus on what its use sometimes conceals in the literature, pointing to issues of vested interest, power, exclusivity, and control. Such questions expose gaps in the literature concerned with arguing for the validity of a particular paradigm in which the ‘evidence’ itself is both embedded in and structured from this paradigm.

Examining the meaning of ‘evidence’, and of the way it is used to provide certainty, also immediately implies the opposite possibility: doubt. By pursuing such threads of meaning the entire evidential structure of the Western total world-view based on science wobbles precariously, if not collapses, because they point to the fact that doubt is the defining characteristic of science, not certainty. The Western total world-view reveals itself concerned with the validation of evidence, but only from a particular viewpoint; it considers doubt to be outside its parameters, even though the evidence is supposed to be informed by science, which is based on doubt; and it considers evidence provides certainty, when science provides only the certainty of temporary hypotheses. Thus, the use of ‘evidence’ in the literature can be deconstructed to reveal that it is reliant on a misuse of science. Disagreement and conflicting evidence indicate that EBM is actually supportive of the scientific principle of doubt, not certainty. That EBM is *supposed* to provide the certainty of a total world-view, but cannot, indicates not problems with the evidence itself but that science, based on doubt, does not possess the characteristics for which it is used.

This is another way of understanding the extraordinary influence that historical orientations can have on why the world is approached as it is in the contemporary West and why medicine’s total world-view, as with the secular West’s total world-view in general, has become such a nexus of complexity and confusion. Medicine’s evidential base needs to be understood in terms of how the Western scientific world-view is as much a belief position as was the religious world-view of the past. Viewed in this way, the abundance of conflicting information and views about depression, from both medicine and sociology, can be seen as a healthy sign of the scientific

endeavour, even though it falls woefully short of enacting a total world-view. ““Medicine does not fail to meet the standards [of EBM]. The standards fail to meet reality”” (Barry 2006: 2649, quoting Berg and Mol). In the quest for medical certainty, the problems surrounding EBM stem from the belief that the evidence must support a total world-view based on science, despite the problems this causes and despite the evident plurality of the world.

It is, then, not that medical science fails in providing valuable insights, understandings, and knowledge but that, characteristically, it inherently functions on doubt. There is an issue of function and expectation: science, and the scientific evidence it pursues, is characterized by a functional modality of doubt and hypothetical possibilities, yet operates in the expectation of securing singularity and certainty. That approaches to depression could be founded on doubt and plurality, rather than on the certainty of single points of view, is untenable in the total world-view of medicine. Total and logocentric world-views inevitably function by changing Other into Same in order to know, understand, and control. While certainty seems preferable, an opinion voiced and insisted upon by Job’s ‘friends’ and Plato, it is the nature of the human condition and also the nature of science that the evidence in life and the world furnishes doubt, not certainty, and plurality, not singularity.

## **5.4 Elite and Laity**

The rise of medicine in the West is one of the most salient characteristics of the modern world, involving rules, regulations, laws, and guidelines, much of which is controlled and influenced by the medical profession (Brown & Zavestoski 2004). In the same way that EBM can be seen as perhaps the most singular and prominent feature of medicine’s total world-view, the medical profession can be seen as the guardians and administrators of this total world-view. “The adoption of ‘scientific’ medicine and the insistence upon standards of rigorous medical education were central strategies in the professionalization process” (Freund & McGuire 1995: 209). Weber considered professions to have replaced priestly elites in controlling the world and the laity (Schroeder 1987), and to have also been influenced by the emphasis in

the Protestant ethic on vocation and control (Roth & Schluchter 1979). In the area of health and illness, doctors “are the successors of priests, witches and shamans whose work seeks to manage those mysterious forces that threaten to destabilize everyday life. The general public do not share in this knowledge” (Shaw & Woodward 2004a: 22). However, this modern medical ‘priestly cast’ has to function in the plurality and individualism of secular modernity. The inherited emphasis on the role and power of the elite, and its relationship to the laity, constitute crucial components of medicine’s total world-view.

The relationship between the medical professionals (the elite) and the general public (the laity) is complex. Medicine controls and validates itself, as do all professions in the modern West, by controlling and vetting the education of those who enter its professions, and in turn, how these medical professionals practice medicine and treat their patients. In addition, the medical elites determine what is normal or abnormal, what is health or illness, and promote the regulation of life through risk surveillance to achieve individual and public normality and health (Lupton 1995, Lauritzen & Sachs 2001). Medicine, as a total world-view, needs the existence of a well-defined and powerful elite to exert control over the world and the laity. This necessity, however, (as with the necessity of singularity, and of evidence and certainty) translates into reality with attendant difficulty because of the plurality of the secular world and, additionally, the place accorded to the individual in the modern world.

Research examining the historical development of the medical profession has demonstrated that its dominance is a product, not of being better than the alternatives but of a concerted power struggle (Freund & McGuire 1995). In the West, medicine represents effective market dominance and through medical professional bodies exerts almost unequalled social and political dominance, which stems not from “technological and scientific knowledge” but “from the successful mobilization of resources to become a profession” (White 2002: 11). For example, the battle between allopathy (the antecedent of Western medicine) and homœopathy highlights the historical animosity between these two groups in a battle to achieve dominance and control. The American Medical Association (AMA) was established in 1847 to help establish the profession of medicine as it is known today. “Between 1850 and 1880, the two camps became polarized, as the AMA censured members who continued to

have dealings with the ‘enemy’” (Freund & McGuire 1991: 208). The dominance of the biological grounding of psychiatry is another example of an intense struggle between differing parties within the profession of medicine (McPherson & Armstrong 2006). As a study in the social construction of power, the consolidation of the authority of allopathy or of biologically-grounded psychiatry, as they struggled to cope with ‘heretics’, is comparable to the consolidation of the authority of the Roman Catholic Church through the Inquisition, as it struggled to cope with heretics. In these instances an examination of the ‘other’, the heretics of healing or the heretics of belief, reveals a struggle for domination and control by an elite.

In a sense, the ‘other’ in a total world-view is always heretical because it threatens to undermine the dominant paradigm and must be controlled or eradicated. The ‘heretics’ were a threat to the authority of modern medicine, of biological psychiatry, and of the Church as, in each case, power was extended and consolidated. In mediaeval Europe what “the Inquisition sought to control above all else was *behaviour*” (Given 1997: 4). Similarly, medicine today, through medicalization and professionalization, essentially seeks to control behaviour, deciding what is normal, what is not, and what treatments are required to re-instate normality. On the one hand, this has been a successful endeavour; on the other hand, however, in providing many benefits there have also been concomitant disadvantages that inevitably arise from the presence and influence of a powerful elite. Nevertheless, today in the contemporary West the increasing presence of other powerful players (such as health insurers, the pharmaceutical industry, social health movements, and corporate providers of health care) in the wider field of health care, of which medicine is only one part, needs to be increasingly acknowledged in any discussion of health and illness (Healy 1997, White 2001, Hess 2004, Villanueva-Russell 2005, Willis 2006). Indeed, the requirements for diagnostic criteria and category numbers to satisfy the health industry is a necessity doctors are now required to abide by, sometimes causing frustration (McBride 2006), even if initially such ‘doctrines’ were used to achieve dominance and control.

This is not to infer that medicine does not seek to control these other players and individuals through its professionals. For example, considerable importance is attached to educating the public about the expertise of medical professionals in

depression diagnosis and treatment (Hickie 2002b, Goldney *et al.* 2005, 2007), about the need for increased and improved screening of the public to advance medical efforts to diagnose and treat depression (Hickie *et al.* 2002, Kessler *et al.* 2002, Friedman 2006, Gunn *et al.* 2008), and about the need for the monitoring of depression across the general public (Mackinnon *et al.* 2004). It is considered that any screening for depression must be under the control of the medical professionals, such as general practitioners (Henkel *et al.* 2003). Emphasis is also placed on public education about mental health stigma (Haslam 2007, Sartorius 2007), mental health generally (Jorm *et al.* 2006a, 2006b, Jorm & Kelly 2007, Friedman 2008), and depression specifically (Cole 2007). Importance is particularly attached to education of the public about depression by medical professionals and various organizations, such as *beyondblue*, and to the monitoring of public depression literacy (Hickie 2002a, Highet *et al.* 2002, 2004, Parslow & Jorm 2002, Jorm *et al.* 2005).

In addition, further training of medical practitioners is considered important to improve detection and treatment of depression (King *et al.* 2002, Hickie *et al.* 2004, Timonen & Liukkonen 2008), and, as with education of the general public, the internet has also been found to be an effective means of educating health professionals (Cook *et al.* 2008). Moreover, by linking web-sites to professional medical organizations the quality of information provided to the general public on the web-sites can be improved (Griffiths & Christensen 2000) and doctors can actively direct the public to appropriate depression web-sites to reduce the spread of internet based misinformation (Bishop 2002). In these instances, the medical elite is clearly exerting control and furthering its influence over the general public and over how depression is framed in the modern secular West.

However, the profession of medicine itself is not a homogenous entity of “‘like minded’ practitioners, and ... interest ... about the possibilities of ‘expanding its empire’ still further ... cannot simply or unproblematically be assumed” (Williams 2001: 144). Indeed, just as the medical profession is not completely interested in exerting authority over the individual and society nor is it able to achieve this (Leibovici & Lièvre 2002), and nor is it blind to the dangers of newer forms of medicalization, such as genetics (Melzer & Zimmern 2002). Hope that “some doctors will now become the pioneers of de-medicalisation ... [and] de-

professionalisation” (Moynihan & Smith 2002) perhaps, however, fails to recognize a number of complex issues. These include: recognition of the difficulties facing doctors due to medicalization (Leibovici & Lièvre 2002) and to the increasing influence of corporate health care providers (White 2001); acknowledgement that there is often a two-way interplay between doctor and patient (Lupton 1997, Blazer 2005); and conceding that sometimes an ill person may simply be happy and relieved to assume “the ‘patient role’, complying with doctors’ orders” (Lawton 2003: 34).

The medicalization of sadness as depression is driven by both doctor and patient (Shaw & Woodward 2004b). While there is a guarded recognition of the notion of the lay expert (Prior 2003), the opinions of the consumer are recognized, nevertheless, as important (Hickie 2002b, McGrath 2002). Moreover, although not diminishing the role of the medical experts, some research (Karp 1996, 2001, 2007) notably views the individuals experiencing depression, and their families, as the ‘experts’, and takes their individual stories as the data from which to draw general understandings about depression while remaining respectful of the multiplicity and diversity of such individual stories. Also emphasizing the role of patients, some medical opinion considers that patients should be able to choose between counselling and medication for the treatment of mild depression (Chilvers *et al.* 2001). Further, the medical response to depression emphasizes the need to institute a multi-level and multi-organizational approach to depression that includes medical professionals, service providers, the government, insurers, schools, and the public (Hickie 2004).

In a sense, there are two types of experts: the one who is the ‘healer’ and the one who is in need of ‘healing’. Both types of experts are ‘expert’ in particular ways and both provide valuable insights and understandings about depression. While medical experts tend to operate according to the certainty of scientific rationality, the lay experts operate from the certainty of personal knowledge and experience in finding the best way to live with depression; the latter often move towards, from necessity, finding some way of negotiating with the chaos wrought by depression in their lives, whereas the former are generally fixated on the certainty of the scientific-medical model of depression which does not include ways of negotiating with the chaos of depression. Nonetheless, the medical professionals retain the dominant position as powerful elites, even as the laity exerts its position and rights.



The laity in secular modernity are becoming more knowledgeable and are attempting to regain some control over health and illness issues (Shaw & Woodward 2004a), which makes the position of doctors, as the elite replacing the priests of a past age, somewhat fraught. Medical professionals are attempting to institute patient-centred medical practice but this clashes with the impetus of EBM in the management of illness (May *et al.* 2006). This collision between professional aspiration and EBM may explain the problems associated with the use of diagnostic criteria. For example, it has been identified that there are problems with using or implementing diagnostic guidelines for depression in general practice, such as the *DSM* or guidelines based on them (Kendrick 2000, Nease & Aikens 2003). I suggest that such difficulties stem from a lack of parity between such detailed and prescriptive guidelines that arise from a medical total world-view and the reality of a complex and pluralistic world. Medicine, in providing via “the language of science what are, fundamentally, socially informed and value-laden explanations of our life chances, ... acts ... as a system of social control” (White 2002: 12), but the medical profession has no choice but to employ such language despite the inevitable problems that this approach causes (Thomas-MacLean & Stoppard 2004). In addition to negotiating these difficulties, medical professionals have to also attend to the often considerable ambivalence or resistance by the public to both the medical position regarding depression and to the professional response to depression (Barr & Rose 2008).

Nevertheless, medical professionals do exert considerable control over the general public and the individual patient in how depression is approached. Primarily the relationship between the medical professional and the individual is heavily weighted to the former, but the position of the latter is strengthened by the plurality of available opinion and views, by the emphasis in the West on individual choice, and by the continual re-definition of boundaries between the doctor and the patient. Utilizing a *via negativa* approach enables an understanding that the relationship between the medical elite and the laity can be seen, like medicalization itself, as *not* characterized by a consistent intent on power and control of the latter by the former. Rather, it is characterized by a complex of contradictory elements in which the medical professional attempts to fulfil the priestly role inherited from the past with the vocational devotion of the Protestant ethic. However, doctors face the reality of a world governed by plurality, not singularity, and with medical evidence at times in

conflict with the reality of the modern individual patient and the changing ethos regarding doctor and patient roles. From a deconstructive point of view, examination of language throughout the medical and sociological literature concerned with ‘profession’, on the one hand, and ‘patient’, on the other hand, reveals the *a priori* origin of the demarcation between the elite and the laity. Also revealed are questions concerning their positions and interrelationships in the modern Western world where the roles of the elite and laity are not as sustainable (particularly for the elite) as they were in the past, but are required to function as in the past because of the existence of medicine’s total world-view.

Medicine, because of its total world-view, seeks to control and dominate, but it is because of the reality of this total world-view operating in the plurality of the modern secular West that such control and domination is not totally hegemonic or consistent. It is made particularly difficult for a total world-view to effectively function because in secular modernity plurality of opinion is actively endorsed and promoted as not only acceptable but necessary for living in the modern world. Medicine may function in the belief of a total world-view, with its own ‘priestly cast’, but it is buffeted by a plurality that simply did not exist in the West’s religious past to anywhere near the same degree. In addition, the priestly elites of the past did not have to contend with the modern ethos of individualism in the determination of how to live in the world. There is little doubt that medical professionals in the modern West do wield enormous power, but that power is limited, if not eroded in part, by other parties and by the elevated place of the individual.

## **5.5 Conclusion**

In this chapter, I explore how historical orientations influence the contemporary Western framing of depression in the areas of singularity and plurality, evidence and certainty, and the elite and laity. I use the literature on depression from both the medical and sociological fields to illustrate how the current medical approach to depression is characterized, as is all medicine and science, by a focus on a total world-view, despite the evident plurality of secular modernity. I also examine the

importance that medicine attaches to scientific certainty and evidence, and the elevated position of the medical professionals over members of the general public. I also draw on literature from the sociology of health and illness where useful for my discussions.

The emphasis on certainty revealed in the depression literature echoes the ‘certainty’ end of the ‘chaos / certainty’ motif of suffering discussed in Chapter Three. Just as Plato stipulated that certainty was necessary to control the chaos of life and suffering so medical and sociological opinion pursues certainty in the quest to control depression. Indeed, the outright rejection of any value in the chaos of suffering and the emphasis on certainty evident in the contemporary framing of depression is analogous to the absence of suffering and the emphasis on the certainty of God’s love evident in songs from Hillsong. In addition, the certainty sought by medicine to deal with the ‘chaos’ caused by depression is sought outside such chaos, as with the approaches taken by Plato or Job’s friends in securing certainty outside the chaos of suffering. The ‘middle way’ promoted by Aristotle and the tragic poets in which attempts to control the chaos of suffering should not be at the expense of what it means to be human is not to be found in the dominant medical and sociological approaches to depression. Nor is there any recognition of finding, like Job or the characters of Tarrou (Camus 1960) or the old man described by Shukhov (Solzhenitsyn 1963) or in some Christian hymns (for example, hymn 262, *TIS* 2006), certainty *within* the chaos wrought by suffering. Nor is there to be found the idea, as Frankl (2004) maintains, that within the chaos of suffering an individual can find self-awareness of personal worth. Rather, as Job’s ‘friends’ sought in theology the certainty to explain suffering so medicine in biology and sociology in society also seek the certainty to explain depression.

The worth of my approach in this chapter is in demonstrating the power of history to influence, determine, and orientate us in ways largely obscured by their *a priori* nature. It is this nature that sometimes makes it difficult to actually see these historical orientations reflected in the literature. One of the valuable benefits of such an historical approach is in preventing an oversimplification of how the world is viewed and understood (MacMillan 2008). Both medicine and sociology could be seriously undermining the value of their approaches to depression by confusing total

world-view with particular perspectives and, subsequent to this, by generating considerable disagreement. While a total world-view promises the simplicity of a ‘correct’ solution, the reality of a plurality of ‘solutions’ results, because of this total world-view, not in inclusive debate about both the positive and negative aspects of different approaches but in contestation about which is right and, by inference, which is wrong.

Science, in the modern secular West, is seen as the all-encompassing and pre-eminent way of viewing, explaining, and understanding the world and everything in it. The medical framing of depression stems from this view of the world: it is fixated on one point of view, centred on one particular way of viewing the world, and focussed on one way of explication. Medicine exhibits the total world-view Weber saw characterizing Western secular modernity, that Derrida saw characteristic of a logocentric world-view, and that Levinas saw behind the West’s impulse to always reduce Other to Same. In its assumed supremacy as the only correct and validated way of looking at the world medicine displays a singularity of vision and a belief in world-mastery that Weber considered secular Western modernity had inherited directly from its Judaic-Christian heritage. Yet, medicine operates in a world in which there are alternative and competing viewpoints, and in the tensions between them can be discerned what Weber considered was a second characteristic of Western secular modernity inherited from its religious past: the re-emergence of the pluralism of indigenous religions. However, this pluralism, instead of being defined by coexistence, is defined by the pursuit of domination. This domination is given potency by the power of the medical elites to perpetrate this dominance, but is also undermined by the flourishing existence of alternative viewpoints (‘inconvenient voices’), such as evident in CAM, and by the presence of other powerful forces, such as the pharmaceutical companies and corporate health care providers.

By examining the historical orientations evident in the West’s contemporary approach to depression, it is possible to understand the drivers behind these approaches and behind the belief structure underpinning the medical view of the world. It is from such a belief system that the historical orientations affect the interpretative, meaning, and public orientations, and finally, influence the possibilities and paradoxes of the future orientations. The importance of the

existence of different opinions regarding depression, particularly the voices that are inconvenient to the dominant medical paradigm, is their corporate ability to allow for difference, at the same time as fuelling debate, and to nurture possibility, at the same time as appraising that possibility. The result may be confused and divisive, but it signals the existence of multi-directional ongoing research rather than total domination by the medical position. The value arising from such contestation is the presence of ‘inconvenient voices’ that, in their continual questioning and criticisms or suggestions of alternative ideas and approaches, proffer glimpses of understandings not bound, or not so tightly bound, by the scientific focus on certainty.

The emphasis on certainty in the total world-view of medicine leads not to a singular certainty but to a plurality of certainties and inevitable contestation between them. However, this is not a negative situation, but a positive one. The ‘inconvenient voices’ herald, in revealing alternatives, the possibility of re-framing depression in contemporary modernity in a way that, while maybe not achieving the reality of pluralism, could certainly extend its boundaries to include the ‘other’. In this way, certainty becomes an evolving entity comprising doubt in the search for elusive certainty, and scientists are content to be chasers of butterflies, glimpsing transient ideas, rather than hunters, searching for permanent facts (Mitchell 2007). Indeed, it is doubt, the primary defining characteristic of science, which consistently leads to, and safeguards, the possibility of ‘other’ in the form of ‘inconvenient voices’.

In focussing on the historicity of the contemporary Western framing of depression, rather than on the specifics of the subject itself, it is possible to gain an understanding of what lies behind present approaches to depression, which is crucial to understanding *why* depression is approached as it is today in the contemporary West. It is not the ‘substance’ in various opinions that fuels contestation, but the ‘premise’ that lies behind these opinions. It is this premise that results directly in problems of interpretation (see Chapter Six) and meaning (see Chapter Seven). There are numerous concerns and calls emanating from the ‘inconvenient voices’ in both medicine and sociology for reappraisal: for example, to “re-think” approaches to mental health and illness (Busfield (2001: 2), to re-include the social in psychiatry (Blazer 2005), to re-examine alternative approaches to depression (Antonioli &

Reveley 2005, Barry 2006), to re-appraise the relationship between ethnicity and mental illness and depression (Coker 2003, Karasz 2005), to re-consider views of medicine as hegemonic and intent on medicalization (Williams 2001, Shaw & Woodward 2004b), and to re-evaluate how to develop less Anglo-American centred mental health policies (Carpenter 2000). These ‘inconvenient voices’ both reflect and originate from the impact of historical orientations in ways that are largely hidden, and tend to coalesce around defining the problem and determining the best solution. In the next chapter, I explore the depression literature from the second ‘leaf’ of the Quatrefoil Model of Historical-Cultural Framing (the interpretative orientations) that deals specifically with these very issues.

# Chapter Six

## Interpretative Orientations: Resistance

**It isn't that they can't see the solution. It is that they can't see the problem.**

(G. K. Chesterton)<sup>1</sup>

**We need to interpret interpretations more than we need to interpret things.**

(Michel de Montaigne)<sup>2</sup>

**I ought to know by this time that when a fact appears to be opposed to a long train of deductions it invariably proves to be capable of bearing some other interpretation.**

(Sir Arthur Conan Doyle)<sup>3</sup>

### 6.1 Introduction

The second part of my theoretical model facilitates a study of how the various interpretative approaches to depression are orientated, which I term 'interpretative orientations'. These orientations reflect, 'in practice', the beliefs in a total world-view and world-mastery and the role of the elites that characterize the historical orientations. Most of these interpretative responses, while often contested, are characterized by a problem and solution approach (see Chapter Four: 4.2.2). In this chapter, my examination of the literature clearly indicates, with the exception of a few of the 'inconvenient voices', that the interpretative orientations are focussed on depression as something to be resisted, where resistance is understood as the only possible approach. Such an approach resides strongly at the 'resistance' end of the continuum between acceptance and resistance discussed in Chapter Three (3.2) as

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<sup>1</sup> Chesterton 1981: 686

<sup>2</sup> Derrida 1978: 278

<sup>3</sup> Doyle 1981: 584

one of the Motifs of Suffering in Western culture. Whether depression is considered a serious individual health problem or a serious social health problem or a combination of the two, it is, nevertheless, unanimously viewed as a problem; a problem to be resisted by correctly interpreting the problem and correctly solving the problem. While such resistance to depression varies in form as well as degree, the existence of the notion of acceptance of depression as an interpretative orientation is only somewhat broached or hinted at in a very few of the ‘inconvenient voices’.

Orientations to the world and to the individual inherited from the past (discussed in Chapter Five) determine the practicalities and particularities of any interpretative response. The parameters of how the world is interpreted are established by how the world is viewed in the first place. The ‘problem’ of depression undoubtedly benefits from various medical and sociological interpretative orientations. It would additionally benefit from an interpretation of these interpretations to understand how they form part of the historical-cultural framing of depression in the contemporary West. My focus in this chapter on explicating *why* the interpretations of depression are orientated as they are also avoids becoming enmeshed in arguments about the correctness of one interpretation over another. To enable these discussions I utilize aspects of Weberian notions of Western rationalism, the Derridean Rousseauistic Interpretation, and Levinasian ideas about the need to label in order to control. In demonstrating how the interpretative orientations are focussed on problem-defining and problem-solving not only is the problem ‘behind’ these orientations revealed to be interpretative in nature, arising from Western rationalism itself, but also that these interpretative orientations are both beneficial and disadvantageous.

## **6.2 The Problem**

The Western scientific focus on defining and solving problems coupled with an emphasis on resistance to suffering results in a particularly Western way of viewing the world, and therefore viewing depression. That depression is considered a problem is virtually an *a priori* position from which the orientations to how depression is interpreted in the contemporary West have their genesis. From this



starting point, the different orientations to depression result in specific interpretations of how to define the problem of depression and how to solve it.

Depression is perhaps *the* ubiquitous disease of the modern age, with medical sources citing it as “the largest determinant of disability in the world” (Andrews 2001: 419), with major depression alone forecast to “become the second leading cause of disability worldwide by 2020” (Glass 2003: 3169). It is widely considered that “timely diagnosis and treatment of depressive disorders ... is imperative” (Moussavi *et al.* 2007: 857). However, while there may be agreement from most, though not all (Hawthorne *et al.* 2008), regarding its prevalence and continuing increase as a major health problem, there is anything but consensus regarding how to deal with the problem.

Medical responses to depression are almost exclusively concerned with scientific diagnosis and treatment while the sociological responses, often bemoaning the dominance of medical science, emphasise such issues as the centrality and importance of social demographic variables, the problems caused by medicalization and professionalization, or ways that the medical approaches could be improved. Nevertheless, sociological responses, with some exceptions (*e.g.*, Horwitz & Wakefield 2005, 2007), often begin from an almost unquestioning acceptance of the medical position on depression, merely adding emphases or aspects (such as gender or work) or specific criticisms (such as lack of attention to socio-economic class or ethnicity) of a sociological nature rather than investigating and assessing the medical interpretative approach in its entirety.

Even a cursory look at leading medical journals leaves one feeling rather dismayed and bewildered about the contested state of opinion regarding depression, despite how well such discussions are argued within each article. This is symptomatic of a Rousseauistic Interpretation in that within each perspective the arguments make sense, only disintegrating when viewed from another perspective. This situation stems from what Weber describes as an inherited belief in a total world-view, which promises mastery and clarity, uncomfortably existing in the plurality of disparate opinion that characterizes secular modernity. In medicine, there is disagreement about how to define depression, about diagnosis, about treatments, and about the

efficacy and risks of various treatments; there is concern about the medicalization of depression itself and the power of the drug companies; and there is uncertainty about the causes of depression and the implications of wider issues. Some opinion considers depression is over-diagnosed and over-treated (*e.g.*, Summerfield 2006c, Parker 2007) while other opinion considers effective management of the problem of depression is hampered by under-diagnosis and under-treatment (*e.g.*, Kessler *et al.* 2003, J. Scott 2006). However, a variety of medical opinion reveals not only disagreement regarding depression but also awareness of how framing affects illness diagnosis and treatment (Aronowitz 2008a), of the “need to reject the ‘one-size fits all model’” (Parker on Williams 2007b), and of the importance of social factors and issues in psychiatric approaches to depression (Blazer 2005). A number of these, such as poverty and gender, are the focus of sociological studies of depression.

The conclusion drawn from reviewing such literature is that there is a great deal of information about depression, but considerable contestation beyond a recognition that an increasing number of people in Western societies are believed to be emotionally suffering. Pilgrim and Bentall (1999: 271) describe the Western medical concept of depression as “confused, woolly and inadequate”, while Rey and Dudley’s (2005: 378) comment regarding depression in adolescents applies equally to depression generally: “If experts disagree, it is little wonder that the public and clinicians are confused”. There is not a single, unified medical or sociological position regarding depression. Rather, there are various positions that are premised on different interpretations, and these can be highly critical of each other. While such difference is a positive sign of plurality of opinion, such difference does not translate into the existence of respectful dialogue that could facilitate the coexistence of difference. Instead, it heralds discord between parties struggling to exert their position as correct over other positions deemed incorrect or deficient in some way.

This discord, I suggest, is symptomatic of a broader problem, stemming not from contestation between differing interpretative positions but from an inherent problem with the problem and solution approach itself. Such an approach inevitably leads to disputation about defining and solving the problem because the focus is on the *what* of the problem and not the *why* of the problem. Weber wrote positively about the advantages of the Enlightenment ideal based on a life of reason, but he also saw that

the way this developed into an emphasis in Western rationalism on scientific rationality was problematic (Schluchter 1989). This is not because Western rationalism is not useful and beneficial, but because it is “specific and peculiar” (Weber 2001: xxxviii), resulting in a “narrowly restricted sense” of “the word ‘rational’” (Brubaker 1984: 44). Unfortunately, when combined with aspects of the Protestant ethic (rejection of anything perceived as irrational and emphasis on the cultivation of the rational) and religious antecedents (belief in a total world-view and world-mastery), this has resulted in interpretative orientations focussed on resistance through a problem and solution approach. This is believed to be the only correct way of approaching the world, and differences of opinion stem from failures or shortcomings of the ‘other’, not from the restricted ability of this approach to deliver definitions and solutions. The ‘problem’, then, is not that the solution to depression cannot be seen (indeed, many solutions are proffered) but that the problem of depression cannot be seen for what it is. Nor is the problem that some facts, in opposing certain deductions, invariably prove capable of *an* alternative interpretation because there may be *many* alternative interpretations, depending how matters are interpreted in the first place and from which perspective such interpretations are made. Rather, it is that, because “the interpreter does not approach his subject as a *tabula rasa* ... [but] brings with it... beliefs and practices, concepts and norms”, no one interpretation can viewed as the correct one (Dallmayr & McCarthy 1977: 288).

In a Weberian sense the ‘problem’ is not Western rationalism itself but the reduction of the world to ‘problems to be defined’ and ‘problems to be solved’ in a scientifically rational way. Similarly, in a Derridean sense the problem is not that interpretations are centred in a Rousseauistic Interpretation but that they are not seen as being centred, or in a Levinasian sense it is not that the faces of the Other are made into Same in order to control them but that this propensity and intent is not recognized and acknowledged. The Western framing of depression is both enhanced and restricted by the Western view of the world: enhanced because scientifically rationalist, centred, and controlling interpretative orientations ensure resistance through definition and solution, but also restricted because they ensure non-acceptance of plurality and rejection of inclusivity. I explore these potent characteristics of the interpretative orientations to depression by focussing on their primary twin traits of ‘defining the problem’ and ‘solving the problem’.

## 6.3 Defining the Problem

In the contemporary world depression is generally considered a major health problem (Mann 2005, Andrews 2001, Glass 2003) and accounts for one third of primary care consultations (Gilbody *et al.* 2003: 3145). In Australia, depression is the most common mental health disorder (Vos *et al.* 2005). However, depression, as it is understood today, would have been an alien definition half a century ago when diagnoses of depression were rare (Healy 1997). As a medical label, depression is a creation of Western twentieth century psychiatry and is “historically and culturally located in very recent times” (McPherson & Armstrong 2006: 57). Ongoing efforts, in both medical and sociological research, to adequately define the problem of depression have produced a plethora of cogent possibilities, often in varying degrees of disagreement. Indeed, to appropriate Pilgrim and Roger’s description of mental health and illness (1999: 11), depression is a “highly contested” problem.

This lack of consensus is indicative of two interrelated factors: the plurality Weber saw characterizing the modern secular world still operating under the auspices of a total world-view and the Western rationalism Weber saw determining how the world was approached and understood. The positive result of this is that there is a variety of opinion, but the negative result is that the differences of opinion are usually considered to stem from misinterpretation of data or not understanding the problem of depression. The latter tend to overshadow the former. The value of the interpretative orientations in my theoretical model is that they demonstrate the framing of the problem rather than becoming entangled in the disagreements between various attempts to define and solve the problem of depression. Despite the lack of homogenous opinion, defining the problem of depression is largely founded on diagnostic concerns. In both medicine and sociology, ways of determining and measuring depression is central to how the problem of depression is defined.

In medicine, depression is considered to affect both mind and body (Insel & Charney 2003) and the diagnostic criteria reflect this approach. However, although this approach is at least partly holistic depression is generally seen as a malfunction of brain circuitry and / or chemical interaction (Davidson *et al.* 2002, Ebmeier *et al.*

2006). While there has been a continual interest by psychiatry in biology (Moncrieff & Crawford 2001), it was *DSM-III*, marking the supremacy of biological over psychoanalytical psychiatry and resulting in an emphasis in diagnosis of depression firmly based in biology, that had a significant impact on how patients were subsequently diagnosed (McPherson & Armstrong 2006). Between *DSM-III* and *DSM-IV*, there was a broadening of diagnostic criteria and a proliferation of sub-categories of depression, which is often cited as the reason for increased diagnosis of depression (Ebmeier *et al.* 2006, Horwitz & Wakefield 2007, Karp 2007) as well as diagnostic confusion (Parker 2007, 2008a) and disagreements over the production of a valid classification system (Joyce 2008).

Defining depression in a restricted scientific manner reflects its origins in a rational framework, even though there is an awareness of a wider perspective. Social and demographic variables (such as poverty, unemployment, stress), while acknowledged by the *DSM-IV* in Axis IV, for example, are subsequently excluded from criteria used to make a diagnosis (Horwitz & Wakefield 2007). This effectively removes such variables from how depression is defined because the “psychosocial and environmental problems” are separated from diagnostic criteria even though they are recognized as having an impact on diagnosis and treatment (Horwitz & Wakefield 2007: 114). The *DSM* approach contradicts the findings of France and colleagues (2004: 228) who found that depression is part of a “multifactorial cluster of negative conditions” that include marginal social status, and of other medical opinion (Heath 2005) that suspects the prescribing of antidepressants when poverty and inadequate housing are the real problems is not uncommon among general practitioners.

Nevertheless, medicine in Western culture decides what constitutes disease through its diagnostic systems of labelling. In Levinasian terms, diagnostic labelling as a process of defining problems translates the faces of Other (the diseases and illnesses) into Same (diagnostic categories of diseases and illnesses) so that in the naming process they may be defined and controlled. “Diagnosis is a thoroughly semiotic activity, an analysis of one symbol system followed by translation into another” (Kleinman 1988: 16). This process of imposing order on the world from a particular perspective, of essentially constructing a reality, constitutes “a major dimension of political power” (McGuire 1990: 290, quoting Bourdieu).

The development of psychiatric labels to define depression and serve as the basis of diagnosis is related to professional development and to the emphasis in Western rationality on evidence-based description. McPherson and Armstrong (2006: 58) suggest a link between the development and maintenance of psychiatry as a profession and the need to establish consistent diagnostic criteria (such as depression), arguing that “control over the diagnostic labelling process was vital” in the creation of “a dominant power base for itself as a profession”. This labelling process, reflecting the eventual dominance of biological understandings of depression, is firmly structured on a scientific foundation. The labelling process continues in the creation of new sub-categories of depression (Ebmeier *et al.* 2006) and of labels for other emotional states such as ‘social anxiety disorder’ (Schneier 2006), ‘panic disorder’ (Katon 2006), and ‘social phobia disorder’ (S. Scott 2006). The recent publication of a number of books (Horwitz 2009) about the complex relationship between consumer culture, the marketing of psychiatric drugs, and the profession of psychiatry (Herzberg 2009, Shorter 2009), which both reflect and drive the search for therapies to treat emotional stress and suffering, indicates such discussions are likely to continue.

Concerns that human emotions have been disembodied, with dysthymic states now routinely diagnosed as mental illness (Williams 2000b), and that normal sadness is now diagnosed as depression (Horwitz & Wakefield 2005, 2007) directly reflect Weber’s concern over the problems inherent in scientific rationality being employed beyond its parameters. This is also reflected in research (Thomas-MacLean & Stoppard 2004: 287-288) finding a “disjuncture” between medical training about depression and doctors’ experiences of the social aspects of depression because the “scientific ideology” of the medical model of depression “fails to address the complex nature of depression”.

Central to the diagnosis of depression is the role of the health professional. Emphasis is often placed, due to poor professional-lay agreement in assessing depressive symptoms, on the expert role of clinicians over members of the public (Parker *et al.* 2003). Other opinion, however, emphasizes the salient nature of patient and family experiences of depression (Highet *et al.* 2004) and the unacceptability of dismissing lay input and the importance of professional-lay partnerships (McGrath 2002). Such

disparate opinions clearly reflect the tensions in the historical orientations concerned with the place of the elite and laity that impact on approaches to health and illness. However, a focus on patient and family can inadvertently reinforce the reductionist model (Freund & McGuire 1995) or “individualist model” (McClellan 2005: 644, quoting Donahue & McGuire) of medicine, as opposed to the social, easily translating into an equation of individual responsibility and recovery. Petersen and Lupton (1996: 118) argue “that more and more ‘environmental’ risks are now conceptualised as amenable to personal control”. All positions reflect, nevertheless, a focus on the need to define depression as a problem so that it can be solved.

Within psychiatry, much emphasis and credibility are attached to correct diagnosis, with clinical criteria usually drawn from the standards set by professional bodies (Mann 2005). The *Diagnostic and Statistical Manual of Mental Disorders* (currently *DSM-IV*), produced by the American Psychiatric Association, and the *International Classification of Disease* (currently *ICD-10*), produced by the World Health Organization, are the dominant diagnostic systems worldwide. While the *DSM-IV* is highly influential and is “the most widely used classification system in Australasia” (Ellis *et al.* 2004a: 892), Parker (2007: 328) considers the increase in diagnosed depression partly due to the “lack of a reliable diagnostic model”. Nevertheless, based on these guidelines, depression is considered to be “qualitatively different” from transient low moods (Ellis *et al.* 2004b: 389). As a diagnostic term, depression is used for describing “a spectrum of mood disturbances ... [that] are judged to be of clinical significance when they interfere with normal activities and persist for at least two weeks” (Peveler *et al.* 2002: 149). Depression is also considered to be a “chronic and recurrent illness” (Keller 2003: 3152) or a “relapsing condition” (Ellis & Smith, 2002: S81), displaying “a high rate of recurrence” (Ellis *et al.* 2004b: 389).

Related to the emphasis on diagnosis is concern with remission and how it is to be defined. In viewing depression as a problem to be resisted, remission from depression is seen not merely as the ideal endpoint, but the *only* endpoint. Importantly, because medical opinion considers remission to be the optimal treatment outcome, the importance of how remission is indicated impacts on the systems of diagnosis and assessment (Keller 2003). Although recurrence rates are high, there are few strong predictors of remission (Eaton *et al.* 2008). The

underlying emphasis in opinions and criteria concerning depression diagnosis and remission is one of resistance; a resistance based on scientific evidence directed at clearly defining the problem of depression in order that this problem can then be effectively solved.

There is debate about depression as a category, however, when it is clearly part of a continuum of mood:

Despite awareness of the continuity between normal sadness and clinical depression, the diagnosis assumes that clinical depression exists as a category (rather than on a continuum). It is unclear, however, who decides where the cut-off mark is, and on what basis. (Timimi 2004: 1395)

Commenting on this issue, Kleinman (2004) considers that some of the uncertainty with diagnosis of depression is due to problems associated with the use of the *DSM-IV* and the way that illness is demarcated from ‘normal’. For example, the *DSM* defines a person as depressively ill if their bereavement grief lasts longer than two months, when it may be considered by others to be “a sign of the moral experience of suffering” (Kleinman 2004: 952). Further, this bereavement clause only includes the death of loved ones and not other major losses for which depression may be considered a normal reaction (Horwitz & Wakefield 2005, 2007, Wakefield *et al.* 2007). There is also considerable diagnostic fuzziness, and associated disagreement, about the dividing line separating other psychiatric conditions, such as anxiety, from depression (Pilgrim & Bentall 1999) and different opinions regarding the diagnostic co-morbidity of depression and anxiety (Moffitt *et al.* 2007).

A strong emphasis on evidence, nevertheless, prevails in the production of psychiatric depression guidelines. In 2004, the Royal Australian and New Zealand College of Psychiatrists produced a set of guidelines for the treatment of depression that relate to both the *DSM-IV* and the *ICD-10* (Ellis *et al.* 2004b). While this paper was strongly criticized from within the profession (Parker 2004a), it is argued by the primary authors of the guidelines (Ellis *et al.* 2004a) that it is evidence-based and makes sound recommendations for the treatment of depression that are in agreement with similar guidelines from the United Kingdom and the United States. The authors of these guidelines admit that their approach “may lack intellectual rigour, but when



some of the best minds in psychiatry cannot agree on the most appropriate classification, a pragmatic approach is required” (Ellis *et al.* 2004a: 892). Such a statement is an honest recognition and assessment of the highly contested area of how to define and diagnose depression, which stands in contrast to those of Rubinow (2006) and Parker (2004a) who consider diagnosis simply reflective of correct scientific approach and classification.

Parker (2004b) is concerned that clinical guidelines should be practical and involve common sense as much as science and theory, but his emphasis and approach are, nevertheless, heavily weighted towards the scientific basis of the medical paradigm and the use of clear diagnostic tools based on multi-dimensional modelling (Parker *et al.* 2008, Parker 2008b). Weighting *DSM* diagnostic symptoms, rather than merely counting, is also suggested as an approach that may help overcome problems with using the *DSM* system (Sakashita *et al.* 2007). It is noteworthy that attempts to rectify problems with diagnostic systems focus on re-modelling the existing approach rather than examining why this approach, a Western rationalist approach, is used in the first place and investigating the difficulties it may be causing.

The emphasis on defining depression is based on diagnosis and a major problem with diagnostic systems is their inherent classificatory approach to depression, particularly when diagnosis is concerned with emotional states for which there are no biomarkers or tests (Insel & Charney 2003, McPherson & Armstrong 2006). This situation explains the emphasis in psychiatry on the future research potential of areas such as genetics (Bennett 2007) and neuroscience (Davidson *et al.* 2002). There is, however, an attendant problem in using specified criteria for diagnoses: when the criteria changes so do the diagnoses. One reason for the increase in rates of depression could be linked to changes in the *DSM* criteria. The “early versions ... drew the boundaries of depression much narrower than *DSM* III or IV” (Ebmeier *et al.* 2006: 153). Defining depression according to scientifically based classificatory systems is problematic (Summerfield 2006a). It can lead to the pathologizing of the human condition, resulting in labels of illness for what in previous centuries in the West were taken to be ordinary aspects, however difficult and painful, of life and living (Shaw & Woodward 2004b, Horwitz & Wakefield 2007, Karp 1996, 2007). Despite concerns about the impact of changing diagnostic guidelines on depression diagnosis

rates (Parker 2007), there is still widespread opinion that depression remains seriously undiagnosed (Peveler *et al.* 2002), perhaps by as much as up to fifty percent in primary health care (Henkel *et al.* 2003).

Nevertheless, the universal relevance of diagnostic tools is challenged in both medicine and sociology. Is depression, as classified in diagnostic systems, “always a timeless, free-standing, coherent, universally valid, pathological entity with a life of its own?” (Summerfield 2006b: 1235). For example, different cultural backgrounds can complicate diagnosis and treatment of depression (Kleinman 2004), with diagnostic systems requiring modification when translated into different languages to make them culturally relevant (Patel *et al.* 2001). Studies of other cultures reveal that the way depression is defined in the West as a health problem that is reducible to diagnostic criteria is culturally constructed (Coker 2003, Skultans 2003, Wight *et al.* 2005). The emphasis on the individual patient in the diagnosis and treatment of depression that characterizes the Western approach to depression contrasts with other cultures that see depression as socially based (Karasz 2005, Lackey 2008).

Issues of gender (Nazroo *et al.* 1998, Bracke 2005, Väänänen *et al.* 2008) and socio-economic position (Meertens *et al.* 2003, Zimmerman *et al.* 2004) also challenge the neutrality and validity of diagnostic guidelines. There has been criticism of diagnostic categories displaying unintended gender preference with a need for gender-neutral diagnostic guidelines containing “gender-sensitive instruments that are more likely to pick up the symptoms of depression in men” (Brownhill *et al.* 2005: 929), and for an integrated model that can solve the puzzle of gender differences in depression (Hyde *et al.* 2008). Other interesting research has revealed that depression predominates as a diagnosis in the middle class whereas schizophrenia predominates in the lower class, and that the middle class suffer from mental illness whereas the lower class inflict suffering on the public because of their mental illness (Olstead 2002).

The way in which diagnostic guidelines fail to allow for the relationship between social factors and depression, and how these can change over time, was demonstrated in a recent Dutch study (Meertens *et al.* 2003: 208) that found between 1975 and 1996 divorced people “became progressively less likely to suffer from depressive

symptoms” as divorce became more socially acceptable. In addition, age has been raised as a factor that current diagnostic guidelines do not adequately cater for. Two-thirds of older people suffering from “serious depression do not have symptoms that fit current classifications of mood disorders, which have been generated to reflect symptoms in younger people” (Chew-Graham *et al.* 2004: 181). There is also concern regarding the diagnosis of depression in children and adolescents (Timimi 2004), despite other concerns that half of adolescent depression is under diagnosed (Ryan 2005). A combination of diagnostic guidelines and clinical expertise in which there is a “careful balance between prudence and validity” is suggested as the optimum approach for dealing with the short-comings of diagnostic guidelines in day-to-day medical practice (Nease & Aikens 2003: 1031).

There are difficulties inherent in a diagnostic approach to depression that is centred on resistance to depression. One of the disadvantages of this resistance approach to depression is that viewing it as a problem to be defined can obfuscate awareness that depression has been labelled as a problem in the first place. There is also a danger that sociology can inadvertently perpetuate dualisms of mind / body and emotion / reason by following medicine in equating unhappiness with mental illness and happiness with mental health (Williams 2000b), even though a sociological perspective is used in which the medical perspective is criticized. Sociological research can be both critical and supportive of the medical position at the same time: supportive of the wider framing (*i.e.*, Western rationalism or a Rousseauistic Interpretation) and critical of the specifics of the medical interpretation of the problem. For example, the controversial nature of some psychiatric diagnoses reflect difficulties with psychiatric diagnosis generally (Manning 2000), but they also reflect origins in a certain way of understanding the world from which such interpretative orientations have their genesis. Similarly, discussions of the role that sociology can play in the area of symptom recognition in mental illness (Palmer 2001) actually aligns such sociological research directly with medicine even as, through its criticisms, it diverges from medicine. There is a danger that sociology risks not only inadequately addressing failings in psychiatry (Horwitz & Wakefield 2007) but also perpetuating and reinforcing society’s paradigms of health and illness (Radley 1999). Nevertheless, sociological research explicating social dimensions is revealing of important information about how depression is defined in the social realm.

Defining the problem of depression, then, results in a variety of approaches and emphases in both medicine and sociology concerned with resisting depression. While there is consensus regarding the need to define the problem of depression there is no consensus regarding what this definition should be. The resulting contestations and confusions over defining depression make it seem ““at once familiar and mysterious”” (Pilgrim & Bentall 1999: 265, quoting Seligman). Examining the differing approaches to depression reveal the interpretative orientations to be firmly grounded in a scientifically rationalist world-view. Such a view is centred, in Weberian terms, in Western rationalism, or, in Derridean terms, in a Rousseauistic interpretative position. Resisting depression through defining it as a problem also reflects the intent, in Levinasian terms, to control the face of the Other by defining and labelling it. This is why an approach in which the interpretations are interpreted helps elucidate the *why* behind the interpretative *what*.

While diagnostic criteria and classifications “remain controversial” (Ellis *et al.* 2004a: 892), their essential characteristic is concerned with defining the problem of depression. The existence of differing interpretations is positive, as it contributes to ongoing refining and expanding of ideas in both sociology and medicine. However, the belief in a total world-view has bequeathed a sense that there is a right way of defining the problem of depression. This often overshadows the values inherent in these various interpretative orientations and tends to draw discussions into disagreements about aspects of these interpretative orientations rather than the form that they take. Similarly, solving the problem of depression also produces equally differing and contested approaches enmeshed in disagreement about details.

## **6.4 Solving the Problem**

Solving the problem of depression involves ‘treatment’ of some sort, even though at present “a measurable critical end point of treatment for depression has yet to be clearly established” (Keller 2003: 3152). Medical responses are interested in treating the individual while sociological responses are often concerned with supporting or criticizing the various medical positions and emphasizing environmental factors,

such as gender or poverty. Analysis of the literature indicates a unanimous emphasis on the value of treatment, but varies in what is considered the best treatment. Solutions are predicated on a belief that the problem has been clearly defined. Previous discussions have demonstrated that, while there is much research and discussion, a consensus definition of depression is not available. Indeed, interpretative orientations founded on a restricted approach (restricted in a Western rationalist or Rousseauistic way or in the narrow emphasis on labelling in order to solve problems) produce a variety of definitions. The solutions subsequently produced are inevitably going to be equally complex and contradictory. If, through scientific rationality, secular modernity cannot produce a universal definition of depression nor is it likely to produce a universal solution. In addition, the belief that science, so central to the Western rationalist perspective, can solve all problems (Morgan 2002) determines how solutions are sought, just as it determines how definitions are sought. The depression literature, particularly from medicine, amply attests to this and results in almost more disagreement within medicine than between medicine and sociology.

The medical profession considers depression to be treatment responsive (Ellis *et al.* 2004b, Ebmeier *et al.* 2006), with effective treatments available (Insel & Charney 2003, Vos *et al.* 2004, 2005, Reifler 2006) that are cost-effective although under-utilized (Kessler *et al.* 2003, Vos *et al.* 2005). The dominant medical position is that medication, in particular, “can successfully treat depression and prevent future episodes” (Mann 2005: 1831). There is, nevertheless, disagreement about the various treatments available (consisting largely of medication, counselling, and physical therapies) and criticisms and disagreements about published treatment guidelines (Middleton *et al.* 2005, Parker 2004a).

The importance of thorough treatment plans that include continuation of treatment to prevent relapses is emphasized within the profession (Ellis & Smith 2002, Vos *et al.* 2004). Indeed, there is evidence suggesting improvements in remission rates can be achieved by longer treatment periods with antidepressants (Reynolds 2006, Timonen & Liukkonen 2008), which can reduce the absolute risk of relapse by about half (Geddes *et al.* 2003). Even though there is no consensus regarding what constitutes remission (Keller 2003, Eaton *et al.* 2008), there is agreement that the monitoring of

treatment is essential. Managing depression as a chronic disease is also considered beneficial to treatment outcomes (Andrews 2001, Rost *et al.* 2002, J. Scott 2006). However, while it is recognized that the whole process of medical care for depressed patients needs to be improved, rather than simply prescribing new treatments (Von Korff & Goldberg 2001), attempts to develop “whole system” approaches to the management of depression have often failed (Scott *et al.* 2002: 953).

Western rationalism has facilitated great success in solving the problems of illness, including depression, but within that success the same rationality produces disagreement and confusion. This is arguably more prevalent in psychiatric illnesses where there are no definitive biological markers or tests available (Insel & Charney 2003) and where emotional and mental states cross the rationalist and scientific dualisms of mind / body and emotion / reason (Williams 2000b). Despite the lack of unequivocal findings regarding treatment for depression, antidepressant medication remains the primary treatment tool (Olfson *et al.* 2002, Ebmeier *et al.* 2006) and different types of antidepressant medications have been found to be efficaciously similar (Geddes *et al.* 2003, Mann 2005). Yet, there is considerable disagreement within the medical profession about both the use of drugs and their efficacy. Peveler and colleagues (2002: 151) found that antidepressants “have been shown to be effective in treating major depressive disorder” and Mann (2005: 1826-1827) found that antidepressants “are the treatment of choice for moderate-to-severe depression”, but in primary care the efficacy of SSRIs for minor depression has not been established (Kendrick 2000). Some opinions insist that in cases of severe depression antidepressant medication treatment should precede any psychological therapy (Ellis *et al.* 2004b) and suggest that “preliminary treatment with drugs” optimizes use of psychological treatment (Peveler *et al.* 2002: 152).

However, reporting on a recent study, Mayor (2008) and Lenzer & Brownlee (2008) detail findings that antidepressants were no more efficacious than placebo, with only a small subset benefiting from drug treatment. In contrast, Turner & Rosenthal (2008) concluded, also referring to the same study, that antidepressants are more effective than placebo and pointed out that differences of opinion often reflect differences in how data is interpreted and that trial efficacy does not necessarily equate with practice efficacy. Another complicating factor in determining effective

treatment is that people “with mood disorders have inherently high placebo response rates” (Charney *et al.* 2002). Treatment-resistant depression is also considered particularly problematic in terms of depression treatment efficacy, and both social and biological correlates are raised as needing further and concurrent research (Wijeratne & Sachdev 2008). Most of the newer antidepressants are variations of older drugs (Insel & Charney 2003) and are generally better tolerated (MacGillivray *et al.* 2003), even though only a few of the newer drugs are superior to the older drugs (Barondes 2003). Opinion varies on the efficacy of using alternative antidepressants if the first proves ineffective (Thase *et al.* 2002, Rush *et al.* 2006) and on using antidepressant combination treatments (Trivedi *et al.* 2006, Horgan 2007, Keks *et al.* 2007a, 2007b, Walters *et al.* 2007, Timonen & Liukkonen 2008). The use of antidepressants combined with other drugs, however, has been found beneficial (Cooper-Kazaz *et al.* 2007).

In recent years, there has been growing concern about the increase in the use of antidepressant medications and such concern is not unfounded given the proliferation of antidepressant prescribing (Olfson *et al.* 2002, Mant *et al.* 2004). However, many members of the public discontinue antidepressant treatments because they consider these drugs to be addictive, which may go some way to explaining why treatment outcomes remain suboptimal (Kendrick 2000), and many patients do not adhere to treatment regimes because of drug side effects (Mitchell 2006). The fact that antidepressants can cause withdrawal or discontinuation symptoms when medications are stopped (Ebmeier *et al.* 2006) could also explain public reluctance to accept drug treatments.

In addition, there is much concern within the medical profession regarding the risks associated with antidepressants (Gunnell & Ashby 2004, Gunnell *et al.* 2005) and the limited or non-disclosure of adverse effects from the drug companies (Jureidini *et al.* 2004, Ramchandani 2004, Simon 2008). In particular, the relationship between antidepressants and the fall or increase in the risk of suicide is a highly contested subject (Ankarberg 2003, Hall *et al.* 2003, Moncrieff 2003, Fergusson *et al.* 2005, Goldney 2006, Hall & Lucke 2006, Friedman & Leon 2007). There is also considerable concern and disagreement about the relationship between youth suicide and antidepressants (Simon 2006, Dyer 2007, Markowitz & Cuellar 2007, Wheeler *et*

*al.* 2008). However, there may be a relationship between trial groups with a high risk of suicide in some studies and overall research results (Rubino *et al.* 2006) or not (Cipriani *et al.* 2007), depending on how the data and risk are evaluated and interpreted. This strongly suggests that scientific approaches to determining treatment can sometimes become a petard. The numerous studies of suicide and antidepressants confirms Parker's (2004b: 413) observation that drug trials produce vast quantities of data "lacking intrinsic substance", reflecting another aspect "of the paradoxical sources of failure-in-success" characterizing medicine (Worthman & Kohrt 2005: 872).

When problems with a Rousseauistic interpretative or Western rationalist position become apparent the reaction is to often direct more effort towards stabilizing and solving the problems in the belief that eventually the solution will be achieved or the problem fully explicated, rather than dispensing with the centred interpretative or rationalist approach and looking beyond to alternative framings. In Levinasian terms, if problems are perceived with solutions arising from the labelling process it is the labels that are investigated and not the impetus to label in order to solve problems and achieve control. Emphasis in the depression literature is thus on the need for more research: for example, on the causality of teenage suicide (Bridge *et al.* 2008), on combining social and neurological factors in diagnosis and treatment of depression (Brent & Mann 2006), on the development of more efficacious types of antidepressants (Norman 2006), on the relationship between stress and depression (Kessler 1997, Monroe & Harkness 2005), on metabolism and neural circuitry in depression (Bremner *et al.* 2003), and on determining the value of current initiatives on suicide prevention (Morrell *et al.* 2007). It is believed that much of this research will be guided by neurobiology and genetics (Barondes 2003) and will significantly improve understanding of the mechanisms of depression (Meyer *et al.* 2006).

The implications of this centred rationalist approach is that efforts to improve the treatment outcomes for depressed patients tend to focus on improving existing treatments or delivery of those treatments, rather than considering alternative approaches. Research into "increasing the number of patients receiving evidence-based interventions remains the challenge" (Whiteford 2008: S102). Such research continues in areas as diverse as: improving general practitioner skills in cognitive



therapy (Blashki *et al.* 2008), detection of unrecognised mental illness (Wilhelm *et al.* 2008), management of patients with unexplained physical symptoms from a psychiatric perspective (Pols & Battersby 2008), and developing an “information ‘clearinghouse’ of evidence-supported programs” gathered from formal (peer-reviewed journals) and informal (government reports and conference papers) sources (Christensen *et al.* 2008). Considerable emphasis is also placed on developing better antidepressant drugs for the treatment of depression (Barondes 2003).

Treatment solutions for depression involving some form of counselling are also the source of much disagreement (Chilvers *et al.* 2001, Olfson *et al.* 2002, Vos 2004). Some studies demonstrate that psychotherapeutic treatments are more effective than antidepressants alone over the long term (Hollon *et al.* 2005, Vos 2005, Hollon *et al.* 2006), but Ebmeier and colleagues (2006) urge caution. There is also disagreement about the effectiveness of counselling for severe depression compared to moderate depression (Beck 2005, DeRubeis *et al.* 2005, Rey & Dudley 2005, Haby *et al.* 2006). For example, DeRubeis and colleagues (2005: 415) found that cognitive therapy could be as effective as medications, “even among severely depressed outpatients”, whereas Rey and Dudley (2005: 378) considered the evidence for counselling to be “flimsy for moderate and severe depression”.

Although cognitive behavioural therapy (CBT) is the primary type of counselling technique, Holmes (2002) casts doubt on its superiority over psychotherapy. Nevertheless, while Ebmeier and colleagues (2006) concluded from their review that there was no evidence supporting one type of psychological therapy over another, they also found the evidence supporting the positive outcome for CBT in reducing depression remission and relapse to be accumulating. Ward and colleagues (2000), however, found that specialist counselling was more effective in treating depression in the short term than general practitioner counselling. The issue of the cost of counselling versus medication is also a source of disagreement with some (Bower *et al.* 2000) finding no cost differential and others (Briggs 2000) questioning such findings. This has led some to consider alternative delivery options of cognitive behavioural-type therapy. Alternatives such as the internet (Christensen & Griffiths 2002, Christensen *et al.* 2004) and computer-assisted counselling (Beck 2005) have been shown to be effective as treatments for depression, but computer-based options

have been judged to require considerably more research and development (Titov 2007).

The emphasis in all these counselling approaches is to ascertain the best way of solving the problem of depression, hence the disagreement about which type is better and comparisons with medication. Comments such as “CBT conveys a longer-lasting impact beyond the time of treatment” (Vos 2005: 689) and antidepressant medication is “largely palliative in nature” (Hollon *et al.* 2006: 308) compared to the long-term effect of cognitive behavioural therapy stress this focus on establishing the most successful solution to the problem of depression. Even psychotherapy, which emphasizes an holistic approach to the person as opposed to seeing depression as a biological or psychological abnormality, still tends to resist depression. For example, in helping patients understand the triggers of depression, psychotherapy gives autonomy to the patient and helps guide treatment options (Biegler 2008). Moreover, the medical use of mindfulness psychotherapies is very much as an adjunct to the treatment of depression (Wilhelm *et al.* 2006) because they help patients focus on awareness of experience in a non-judgemental manner (Melbourne Academic Mindfulness Interest Group 2006, Ludwig & Kabat-Zinn 2008). However, as is characteristic of biological-based approaches to depression and mental illness, there is an emphasis on caution and the need for more research about psychotherapy (Leichsenring & Rabung 2008) and mindfulness (Wilhelm *et al.* 2006, Ludwig & Kabat-Zinn 2008). These salient characteristics of caution and belief in future research reflect the emphasis in Western rationalism on scientifically verifiable evidence in all treatment responses to depression and the faith that one day science will provide the best answers to solving the problem of depression.

The solution approach to depression, despite differences of opinion on the merits of various treatments, focuses attention on trying to remedy the perceived problem of depression with available treatments. From their analysis, Ellis and Smith (2002: S78) suggest that “there is less to be gained from the selection of a particular treatment than from good compliance with any of these treatments”. Overall, the evidence concerning drug and counselling therapies is contradictory. Combination treatments seem more generally acceptable to the medical profession and are widely considered to offer the best treatment outcomes (Keller *et al.* 2000, Olfson *et al.*

2002, Mann 2005), but combined therapy is not without disagreement (Glass 2004, TADS Team 2004, Hollon *et al.* 2006). Opinions concerning the treatment of depression in children and adolescents, however, are particularly divided. They range from: rejection of antidepressants (Jureidini *et al.* 2004, Timimi 2007), to emphasis on counselling (Haby *et al.* 2004, Asarnow *et al.* 2005) or combined therapy (TADS Team 2004, Weisz *et al.* 2006, Goodyer *et al.* 2007), to cautious endorsement of antidepressant use (Cotgrove 2007), to promotion of school-based education programmes (Burns *et al.* 2002). Opinions regarding treatment of depression in the elderly, while perhaps not as contested as those concerning children and adolescents, also vary and also place emphasis on future research and the importance of evidence in judging treatment efficacy (Alexopoulos 2005, Frazer *et al.* 2005, Reynolds *et al.* 2006).

The medical emphasis on determining the most efficacious treatment for depression and the increasing use of technology converge in the use of electroconvulsive therapy (ECT) for depression. While both the public and medical profession have misgivings about ECT (Carney *et al.* 2003), it nevertheless “remains the most effective treatment for depression” (Ebmeier *et al.* 2006: 161), but is “widely stigmatised as a last-resort treatment” (Fink & Taylor 2007: 332). ECT is considered appropriate when antidepressants fail or are not tolerated (Lisanby 2007) and its efficacy in preventing relapse is similar to some medication, although both have a limited efficacy (Kellner *et al.* 2006). Despite continued medical interest and research into ECT and other physical treatments (Fitzgerald 2003, Mitchell & Loo 2006, Shuchman 2007) they remain largely marginal in use compared to pharmaceutical and psychological therapies, but research continues into developments of alternative approaches to optimise treatment outcome and reduce side-effects (Loo *et al.* 2006).

The overriding determinant of solutions to the problem of depression is efficacy. It is the emphasis on efficacy that underpins the need to label in order to secure control, something Levinas considered characteristic of Western culture. EBM is the litmus test used to gauge the value of all depression treatments and the randomized control trial (RCT) is the favoured method of carrying out such tests. However, as these tools of efficacy are constrained and influenced by a total world-view and the role of

powerful key players other than the medical profession (see Chapter Five) as well as scientific rationality they inevitably confuse and complicate assessment of solutions to the problem of depression. Indeed, Parker (2004b: 413), who is very critical of drug trials, considers that they produce “mountains of data” that are lacking in worthwhile material. There is no doubt that opinion regarding how to treat depression is divisive, resulting in information about the possible solutions being confusing and contradictory. In particular, the influence of the pharmaceutical industry through restricted and biased publication of evidence (Dewhurst 2004, Geddes & Cipriani 2004, Healy 2007, Turner *et al.* 2008) and industry influence on doctors (Campbell 2007) potentially affects the treatment options selected. This reflects a significant and specific issue concerning what actually constitutes the evidence base of depression treatment as opposed to what is intended through the use of EBM. In addition, there are disagreements and concerns about the place and value of evidence-based approaches to the evaluation of counselling therapies (Tonks 2002; see also Holmes 2002 and responses and comments to this article).

Some studies of antidepressants indicate that they are generally effective with at least a fifty percent reduction in symptoms for about seventy percent of patients (Insel & Charney 2003), yet other studies report that the efficacy of drugs is known to be not much above fifty percent (Keller *et al.* 2000, Mann 2005, Rubinow 2006). Moncrieff (2005) and Moncrieff and Kirsch (2005) point to considerable evidence in studies indicating that antidepressants have no advantage over placebo, even for severe depression, and Scott (2000: 1518) observes that the “poor response of patients with chronic depression to treatment with antidepressant drugs alone is not fully understood”. Further, it has also been found that patients “prescribed antidepressants had a slightly worse outcome than those not prescribed them” (Moncrieff & Kirsch 2005: 157), that people who were not “recognised as depressed did slightly better than those that were” (Summerfield 2006b: 9518, referring to research by Goldberg *et al.*), and that older women with mild depression lived longer than those without depression (Hybels *et al.* 2002). Nevertheless, despite such disagreements, confusions, and apparent anomalies, the emphasis on science as both the source of treatment options and the judge of these treatment options predominates discussion and research. This is seen in research about the use of neurocognitive functioning to gauge remission (Gallagher *et al.* 2007), about possibilities for new treatments, such

as antihyperglycaemic treatment (Young 2006), and about ways of predicting vulnerability to future relapse, such as baseline metabolism (Bremner *et al.* 2003).

Alternative treatments for depression do not sit well as treatment solutions largely determined by a total world-view and Western rationalism (see Chapter Five). An Australian review of the efficacy of complementary and self-help treatments for depression (Jorm *et al.* 2002) found hypericum, physical exercise, and self-help books (those using cognitive behaviour therapy) to have the best evidence; however, it was also reported that while many of the complementary treatments warrant further research, none of them is as well supported by evidence as are the standard treatments of antidepressant drugs and cognitive behavioural therapy. There is even less evidence concerning the use of complementary treatments for children and adolescents, even though their use is widespread (Jorm *et al.* 2006c).

While the problem and solution approach that characterizes the interpretative orientations to depression encourage concerted efforts to define and solve the problem of depression, in both medicine and sociology, the restricted nature of this approach privileges some possibilities over others, and even denotes some possibilities as having no efficacy. It is for this reason that alternatives such as hypericum (Philipp *et al.* 1999), animal therapy (Antonioli & Reveley 2005), exercise (Lawlor & Hopker 2001, De Moor *et al.* 2008), bibliotherapy (Anderson *et al.* 2005), spirituality and religion (Hassed 2000, Smith *et al.* 2003, D'Souza 2007), mindfulness (Kostanski & Hassed 2007), or prayer (Jantos & Kiat 2007) are either not generally accepted by the medical profession as proven and effective standard treatments for depression or are viewed cautiously while awaiting further research.

Sociological research often concentrates on specific aspects of depression and its relationship to various social factors, such as the characteristics of work and depression (Ylipaavalniemi *et al.* 2005), social support and depression (Heponiemi *et al.* 2006), homelessness and depression (Irwin *et al.* 2008), gender, work, social support and depression (Plaisier *et al.* 2007), and volunteering and depression (Musick & Wilson 2003). Particularly interesting is research revealing that in the United States, where there is no free public health system, privately insured patients “were almost twice as likely to receive an antidepressant prescription as self-paying

patients” (Sleath & Shih 2003: 1342) whereas in Canada, where there is a universal public health system, no relationship between drug treatment options and income was found (Rhodes *et al.* 2006). In sociology, as in medicine, there is a perceived need to improve strategies to effectively treat depression in the elderly (Murray *et al.* 2006) and to understand depression in young adults (Zimmerman *et al.* 2004).

Recent research suggesting that depression treatment could be improved by enhancing the patient-doctor relationship (Malpass *et al.* 2009) reflects my observation that much sociological research virtually exists within or alongside the medical paradigm. The research on gender and depression (Nazroo *et al.* 1998, Bracke 2000, Griffin *et al.* 2002, Rhodes *et al.* 2006, Ross & Mirowsky 2006), while providing fascinating and valuable information, exists virtually as an adjunct to medicine. For example, research about masculinity and depression (Emslie *et al.* 2006) or findings that popular categories of normality and illness in women’s conceptions of depression have been influenced by the depression treatment itself (Metzl & Angel 2004) add considerably to our general understandings of depression but not to a wider consideration of how depression is framed in the first place. Sociological research seems often concerned with the minutiae of detail rather than with a meta-perspective. The latter (*e.g.*, Blazer 2005, Horwitz & Wakefield 2007) is to be found in proportionately less sociological or medical research.

In the same way that defining the problem of depression was fraught, multi-vocal, and contradictory, providing much information and understanding about depression, so are efforts to solve the problem of depression. The treatments for depression are varied, but highly contested. Parker’s (2008a) opinion that the treatment a patient is likely to receive for depression will depend on the training and interests of the doctor reflects an honest appraisal of the conflicted situation with regard to how depression is treated, and the influences impacting on this. Despite the variety of treatment options, primarily drugs and / or counselling, there is an overall emphasis on maintenance of treatment: “*it is not so much what you do but that you keep doing it*” (Ellis & Smith 2002: S78). The difficulty of acceptance of alternative treatments reflects the historical orientations of a total world-view and the pervasive influence of Western rationalism, the exclusive nature of the Rousseauistic Interpretation, and the emphasis on solving problems through correct labelling. Sociological research,

while detailing the importance of social issues such as gender, generally begins *from* the medical position regarding the need to solve the problem of depression in what amounts to an acceptance rather than an analysis of the medical position: there tends to be difference and disagreement over details but similarity and agreement over generalities of framing.

## 6.5 ‘Inconvenient Voices’

An approach to depression that resists it, rather than accepts it as a part of the human condition, positions all future developments, whether of a sociological or medical nature, along a certain continuum. In examining depression in the Australian news media from the medical, psycho-social, and administrative discourses Rowe and colleagues (2003: 693) found that none of these questioned “the definition or existence of depression as a individualised, reified, condition”. That other interpretative orientations to depression may not begin from a position of resistance, and therefore be contained and constrained by a problem and solution approach, is anathema to Western rationalism or the Rousseauistic interpretative position or the Western impulse to label. Equally, that other interpretative positions, so deemed because they variously question the validity of the dominant approaches to depression and seek alternatives, assume the position of ‘inconvenient voices’, when they too are also characterized by a resistance approach to depression, is testimony to the dominance of resistance-based interpretative orientations in the contemporary Western framing of depression. Resisting depression through a problem and solution approach is an *a priori* position, and differences in interpretation stem from *how* this interpretation is carried out, not *why* it is carried out.

Williams (2000b: 572) argues that “far from being ‘unhealthy’ or ‘pathological’, it is indeed quite normal if not healthy to feel dissatisfied, disillusioned or even downright depressed at times”. Ideas that perhaps “depression has become the expression of ... the difficulties of living in the era of late modernity” (Kangas 2004: 87), where the problem of the absence of happiness is seen as an individual problem rather than a social problem (Shaw & Taplin 2007) become ‘inconvenient voices’

that question the resistance approach to depression as an individual illness. There are some 'inconvenient voices' from both sociology and medicine that, while not entirely dispensing with a problem and solution approach, negotiate different paths because of dissatisfaction with current approaches (Dowrick 2004, Servan-Schreiber 2004, Horwitz and Wakefield 2007).

Overall, the 'inconvenient voices' in the interpretative orientations are best described as challenging, providing nuances, arguments, and perspectives alternative to the general concerns of medicine and sociology (*e.g.*, Pilgrim & Bentall 1999, Blazer 2005, Horwitz & Wakefield 2005). Others provide valuable insights about the emphasis on treating the individual as opposed to society for depression through examination of approaches to improving happiness (Shaw & Taplin 2007). Still other 'inconvenient voices' are to be found in research that facilitates a glimpse into the personal stories of those living with depression, revealing that people's interpretations of depression are complex and diverse, often concerned as much with resistance to depression as with some form of acceptance (Karp 1996, 2007). From another perspective, alternative therapies for depression (*e.g.*, Antonioli & Reveley 2005, Szegedi *et al.* 2005) are reflective of the situation where 'inconvenient voices' are both inconvenient to the dominant paradigm at the same time as they also resist depression in their own problem and solution approach. As such, these 'inconvenient voices', while inconvenient to the contemporary framing of depression, still approach depression as something to be resisted.

Contemporary approaches to depression, whether medical or sociological, have provided valuable insights to human emotional suffering. However, because they function out of the paradigm of Western rationalism that favours scientific rationality, a position greatly strengthened by the rejection of irrationality promoted by the Protestant ethic, both disciplinary approaches are concerned with resistance, and therefore focus on a problem and solution approach. These approaches concerned with resistance reflect the positions of, for example, Job's 'friends' or Plato in their resistance to human suffering and their attempts to remedy and prevent suffering through a focus on solving the problem of suffering. There are some in medicine and sociology that seek to redress the emphasis on defining and solving the problem of depression, but even these 'inconvenient voices' often still tend to



operate from a resistance position concerned with definition and solution. Certainly, these ‘inconvenient voices’ do not embrace the acceptance of suffering demonstrated by Job, or value suffering as leading to the beautiful and the valuable, as did Aristotle and the tragic poets, or actively accept suffering as part of the human condition, as do some Christian hymns. Nor is there any sense of the joyous acceptance of suffering as seen in the character of Alyosha (Solzhenitsyn 1963) or of the resistance to suffering located *within* acceptance of suffering as in the characters of Dr. Rieux (Camus 1960) and Shukhov (Solzhenitsyn 1963). Nevertheless, the existence in medicine and sociology of ‘inconvenient voices’, in raising issues and concerns over the contemporary ways that depression is classified and treated, reflect both the plurality Weber saw re-emerging in secular modernity and the liminal existence of substantive rationality that he saw ‘pushed to the edges’ by Western rationality. The focus of these ‘voices’ inevitably foreground matters to do with orientations to the meaning of depression in the contemporary West, which is the focus of Chapter Seven.

## 6.6 Conclusion

The focus in this chapter is on examining the interpretative orientations evident in the contemporary Western framing of depression. While indicative of only one perspective, my approach is useful in that it reveals these orientations to how depression is interpreted to be largely characterized by a problem and solution approach based on resistance. They reflect both aspects of the historical orientations concerned with a total world-view, plurality, and the elite, and what Weber termed the “specific and peculiar” (Weber 2001: xxxviii) nature of Western rationalism. I am interested, as in previous discussions, with the *why* behind the *what* of how depression is approached. To facilitate this perspective I utilize concepts drawn not only from Weber concerning rationality and Western rationalism, but also from Derrida concerning the Rousseauistic Interpretation, and Levinas concerning the impulse to label and control. Thematically, discussions in this chapter are linked to the motif of suffering (see 3.2) concerned with acceptance and resistance, where the latter is so dominant as to have assumed an *a priori* quality. This *a priori* nature is

also a feature of the certainty provided by belief in a total world-view that characterizes the historical orientations. Together, both of these *a priori* characteristics demonstrate that the ways in which the world is approached and understood in the West are so deeply embedded that they can often remain unseen or easily overlooked.

The various approaches to interpreting depression originate from a desire to alleviate human misery and emotional suffering. While there may be complicating factors of professionalism (the place and role of the elite) and other key players (such as the pharmaceutical industry, corporate health care providers, and health insurers), the value and advances that both medical and sociological approaches to depression provide, I suggest, are both restricted and overshadowed by the dominance in the West of a particular way of seeing the world. All the various interpretative orientations, such as how to define depression according to classificatory systems or according to social factors (*DSM* or gender, for example) and solve depression through various treatments or social interventions (antidepressants or gender awareness, for example) provide different aspects of how to understand depression, even if the problem is never definitively defined or solved. While all such interpretative orientations are examples of the Levinasian impulse to label that which is ‘other’ in order to control it, such labelling and controlling does add to the growing information about depression even if the impulse as to why this occurs is not always recognized as such.

The present medical position on depression is bewildering and overwhelming in its contradictions, disagreements, and confusions. Some of this stems from the production of conflicting data and some from conflicting interpretations of the available research data. Both “clinicians and academics across medicine interpret the same data differently” (Ellis *et al.* 2004a). In addition, some clinicians and academics (Rubinow 2006, Parker *et al.* 2008) are so entrenched in the medical paradigm that they cannot see beyond it, while others (Dowrick 2004, Blazer 2005, Summerfield 2006a) are able to consider the problem of depression in far wider contexts. Moreover, many health professionals have built entire careers on pursuing certain points of view, such as the diagnostic systems (Horwitz & Wakefield 2005), and are unlikely to easily change direction, even in the face of mounting contrary

evidence. This is particularly so when interpretation of existing evidence can vary so widely and is so contradictory. All such factors contribute to the ambiguous picture of depression evident in the variety of conflicting interpretative responses.

Interestingly, though, while it is recognised by some within the medical profession that a new paradigm is needed, often the proposed one continues to view depression as a problem to be resisted. For example, Jan Scott's (2006: 986) comment that we "need a paradigm shift to recognise that depression is a life course disorder" does not reconsider the position of resistance to depression in favour of some sort of acceptance of depression. On a related and equally interesting point, it is noteworthy that despite the various disagreements about the diagnosis and treatment of depression, and the unanimous need to improve outcomes, it is also generally considered that existing diagnosis and treatment strategies could be improved by public screening (Hickie *et al.* 2002) and by increasing and monitoring public depression literacy (Parslow & Jorm 2002, Jorm *et al.* 2005, Cole 2007) rather than by completely 're-thinking' depression itself. Both these situations reflect the centred and self-referential nature of Western rationalism and the Rousseauistic Interpretation, where solutions and improvements are sought within existing framings rather than without. The latter position would require attempting a 're-thinking' of the existing parameters.

Beliefs in single truths, in the certainty and resistance they provide, are always seductive in their simplicity and universality. Derrida's Rousseauistic Interpretation centred on one self-referential and self-validating perspective of the world or the Western rationalism Weber saw characterizing secular modernity are both examples of positions governed by single truths. Their value is that such a focussed approach to defining and solving problems provides many insights and benefits, whether of a medical or sociological nature. The disadvantages are that they tend to preclude other possibilities. This is most clearly seen in the difficulty that medicine has of, in actuality, including factors considered central by sociology. Similarly, the impulse to achieve mastery through a focus on labelling, that Levinas identified as characteristic of Western culture, provides many benefits in scientific advances but also disadvantages in restricting the focus to this labelling process. Ultimately, then, both medicine and sociology are contained and constrained by their respective parameters

that, while providing insights, understanding, and information, tend to exclude other possibilities.

Busfield (2001: 5-6) recognizes this problematic in her criticism of social construction and her suggestions, following research in the areas of language and framing, of employing approaches characterized by social “‘framing’ or ‘structuring’” as a way of approaching the study of mental illness that incorporates both the social and the reality of suffering. Similarly, Pilgrim and Bentall (1999) are critical of both the medical model and the social constructionist model, preferring a model of critical realism that incorporates historical and cultural factors while not losing sight of the reality of emotional suffering. Horwitz & Wakefield (2007), also critical of both the medical and sociological positions, emphasize that the confusions over the distinction between normal sadness and illness are causative of present problems in approaches to depression.

It is medicine, however, that perhaps arguably has the greatest problem with suffering, because in resisting suffering medicine fails to acknowledge suffering as a constituent part of the human condition. In the interpretative orientations can be seen both the influence of historical antecedents and the cultural framing of interpretative responses to depression based on defining and solving the problem of depression as the *only* way to approach such emotional suffering. Indeed, interpretative orientations centred on Western rationalism and resistance to depression can *only* produce interpretations of a certain kind: those intent on defining the problem of depression and on solving the problem of depression. The problem and solution approach is the *raison d'être* of Western rationalist thinking, pervading not only science but also all forms of Western thinking. In my approach of interpreting how depression is interpreted reveals this focus on definition and solution. These orientations, influenced by the historical orientations, in turn influence the meaning orientations, which are discussed in the next chapter.

## Chapter Seven

# Meaning Orientations: Causality

**But the tears are necessary.... I'm claiming the right to be unhappy.**

(Aldous Huxley)<sup>1</sup>

**Nasruddin became prime minister to the king.**

**Once, while he wandered through the palace, he saw a royal falcon.**

**Now Nasruddin had never seen this kind of 'pigeon' before. So he got out a pair of scissors and trimmed the claws, the wings, and the beak of the falcon.**

**'Now you look like a decent bird', he said.**

(Anthony De Mello)<sup>2</sup>

**'When *I* use a word,' Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean - neither more nor less.'**

**'The question is,' said Alice, 'whether you *can* make words mean different things.'**

(Lewis Carroll)<sup>3</sup>

## 7.1 Introduction

In this chapter, I explore the fascinating terrain of meaning and depression, and discover that some meanings of depression are privileged while other meanings are closed off. Overall, both medicine and sociology provide restricted meanings of depression concerned with causality, which I term 'meaning orientations'. Although beneficial, these meaning orientations curtail the range of possible meanings within narrow parameters, and it is only the presence of 'inconvenient voices' that preserves other possibilities of meaning. There is a strong emphasis in the medical and

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<sup>1</sup> Huxley 1955: 185, 187

<sup>2</sup> De Mello: 1984: 7

<sup>3</sup> Carroll 1970: 269

sociological literature on investigating and explaining the causes and processes of depression, reflecting the ‘causality’ end of the highly polarized ‘relationship / causality’ motif of suffering discussed in Chapter Three (3.3). In applying the third part of my theoretical model (see Chapter Four: 4.2.3) to the depression literature I continue to draw upon Weber’s ideas about Western rationalism, with a particular focus on rationality and meaning. I also utilize Derrida’s concepts of the two interpretative positions and Levinas’s concerns about how Other is approached.

Western rationalism has done something quite ‘specific and peculiar’ to meaning, and this ‘something’ becomes apparent when examining what meanings are facilitated in the depression literature, what meanings are partially facilitated, and what meanings are not. Meaning orientations in the contemporary Western framing of depression arise from the historical and interpretative orientations to depression explored in Chapters Five and Six. Indeed, just as the historical orientations (total world-view) determine the parameters of the interpretative orientations (defining the problem and solving the problem) so the interpretative orientations, in turn and in conjunction with the historical orientations, determine the parameters of the meaning orientations (investigating and explaining the problem), yet also create the circumstances from which dynamically arise ‘inconvenient voices’.

## **7.2 Background**

To talk about ‘meaning’, the meaning of any aspect of life, such as depression, or life in its entirety, is perhaps “rash ... [and] is a subject fit either for the crazed or the comic” (Eagleton 2007: ix). Nevertheless, such is the “‘irrepressible quest for meaning’” (Morgan 2002: 307), such is the compelling need “to impose meaningful order upon reality” (Berger 1967: 22), and such is the power of pain to shatter life and force “‘the question of its meaning ... [as] no other experience demands’” (Morgan 2002: 310, quoting Bakan) that to avoid the subject of ‘meaning’ in my discussions of the contemporary Western framing of depression would be a serious omission. Certainly, the topic of depression and meaning is complex and potentially confusing; the latter stemming, I suggest, from the quintessential problem of Western

rationalism that Weber saw hinging on meaning. However, it is this very problematic that provides an access point to understanding the issues of depression and meaning.

### 7.2.1 Terminology

I want to briefly draw attention to an intriguing matter concerning ‘meaning’ and ‘depression’. This matter is central to understanding the meaning orientations in the contemporary Western framing of depression and is directly reflective of issues Weber saw resulting from the conflict between different and “irreconcilable” value spheres and rationalities (Weber 1991: 147, 152). “Words are not dead husks waiting to have meaning breathed into them” (Eagleton 2007: 61); rather, their meanings are constituted by the very language and culture in which they are embedded. Both the words ‘meaning’ and ‘depression’ indicate certain definitions that allow their usage in communication of ideas and opinions, but that also contribute to miscommunication and, therefore, misunderstandings.

The word ‘meaning’, as with the word ‘depression’ (see 1.2.1), is a generic term in both the public and academic domains, and is generally characterized by a multiplicity of denotation and connotation. These words are often used without clarification as to their precise definition. This makes their usage in any discussion difficult and fraught with potential, and unavoidable, hazards. It is not a question of *making* words mean different things. Rather, it is that different meanings will be *assigned* by people holding different perspectives and ideas. None are wrong; none are right: they are simply different, each with its own inherent value.

The depression literature does not reveal contestation and endless discussion over the correct definition of ‘meaning’, or the problems associated with various definitions, as it does over the definition of ‘depression’. Rather, there is either absence of the word ‘meaning’ or accusations that medicine cannot provide the meaning of depression. While philosophy and religion may endlessly debate ‘meaning’, science does not. Indeed, meaning is something that is often inferred in the literature, rather than specifically stipulated. It is the perceived lack of meaning, complained about by some, that draws attention to the place of meaning in the West’s dominant model of

depression. The words ‘depression’ and ‘meaning’ do not have one meaning: they have many meanings. This is the great value of plurality. The meaning orientations in the contemporary framing of depression reflect what happens when one meaning assumes dominance over other meanings and plurality of meaning is marginalized.

### **7.2.2 Implications**

Following Weber (see 2.3, particularly 2.3.3), I suggest this complex situation regarding definition is reflective of the enormous influence of Western rationalism and the potency of scientific rationality. There are two important points. Firstly, the meaning of depression is often not directly discussed in the medical and sociological literature because the ‘meaning’ is considered synonymous with ‘interpretation’. Although representative of different types of science, both sociology and medicine are concerned with defining and solving the problem of depression. Secondly, when meaning *is* referred to in the literature it tends to point to the inability of medicine, as a science, to provide meaning. Both of these are characteristic of the impact of Western rationalism on meaning. As Weber discussed, scientific meaning is restricted to scientific explanations and cannot provide “any meanings that go beyond the purely practical and technical” (Weber 1991: 139). It is this inability to move beyond “concept” and “rational experiment” (Weber 1991: 141), to move beyond matters of a calculable and controllable nature, that focuses meaning on measurable causality and process. When critics state that medicine cannot provide meaning what they are really saying is that Western rationalism, in its emphasis on scientific rationality, cannot provide meaning of a substantive type, not that no meaning is provided. As Kleinman (1988) observes, illness does have meaning, but there are a variety of meanings and the scientific meanings are overvalued in the Western medical quest to treat illness and have assumed dominance over psycho-social meanings.

Overall, then, ‘meaning’ in relation to depression has two aspects: the presence of meaning of a scientific nature that is concerned with interpretation, investigation, and explanation; and the absence of meaning of a rationally substantive type. This constitutes the problem of discussing depression and meaning. There is ‘meaning’



(scientific meaning) and there is ‘meaning’ (spiritual / existential meaning); but the meanings of such ‘meanings’ are different! The contemporary Western framing of depression reveals meaning orientations dominated by Western rationalism and a focus on causality, while ‘inconvenient voices’ point to other meanings.

Both medicine and sociology *do* provide meanings of depression. While science cannot provide meaning of a substantive rational type, it can provide meaning of a formal rational type. It is pejorative, I feel, to claim that the contemporary paradigm of depression provides no meaning. It is also something of an insult to the mammoth efforts in both medicine and sociology directed at explicating depression to simply state that meaning is not provided. The driver behind such negative comments is the aching loss in Western rationalism of substantive rationality (particularly ethical substantive rationality) under the domination of formal rationality and the intellectual value sphere. Weber gloomily saw this confluence as an “iron cage” (Weber 2001: 123) or “a polar night of icy darkness and hardness” (Weber 1991: 128) and that others speak to, often unknowingly, when they say medicine cannot provide meaning. Instead of adding to such criticisms, and further promulgating the divide between scientific meanings and other meanings (particularly substantive rational meanings), and in the spirit of ethical respect by which this study is guided the following discussion therefore proceeds in three directions. Firstly, I acknowledge the human need to search for meaning (7.3); secondly, I affirm the meanings provided about depression in much of the biological and sociological literature (7.4); and thirdly, I examine the many ‘inconvenient voices’ that speak directly to the problem of the meaning of depression in the contemporary West (7.5).

### **7.3 Depression and the Search for Meaning**

The individual “search for meaning ... sits uneasily” in the modern rationalist world where “suffering has no place in the medical lexicon at all” (Morgan 2002: 318-319, referring to Wall, and Cassell) and where “secularisation frustrates deeply grounded human aspirations” of meaning (Berger 1977: 79). However, because of the loss of substantive rationality in the West there is a vacuum of meaning and this is filled by

science, which, as the new total world-view, is certain of its mastery of the world and rejects anything outside its domain. The interpretative orientations discussed in Chapter Six revealed approaches to depression to be generally characterized by defining and solving the problem of depression. Foundational to these twin features is what amounts to an *a priori* position that views depression as a problem; that is, depression is seen as something to be resisted because it is ‘other’. Coupled with the historical orientations characterized by a total world-view, certainty, and a governing elite, the interpretative orientations confer on the meaning orientations a quintessentially Western rationalist perspective.

Moreover, there is a transference of interpretation into meaning that is virtually a conflation because meaning and interpretation become synonymous under Western rationalism. The possibility of the existence of other meanings not tied to scientific rationalist interpretations and not originating from evidence-based cause and effect is outside the confines of Western rationalism. Weber considered science itself to be a religion (Roth & Schluchter 1979) and to function on presuppositions (Weber 1991) because it is a paradigm of belief and therefore determines, and then controls, what those ‘beliefs’ are and what meanings are possible. It is because Weber was “obsessed ... with the meaning of modern life” (Alexander 1987: 185) and sought to understand the characteristics of Western rationalism and the complex relationship between rationality and meaning (Weber 1991) that his concepts are so useful in my exploration of meaning and depression in the contemporary West.

I situate my discussions of depression and meaning at the nexus between affirmation and questioning. This approach builds on the premise that the search for meaning constitutes a basic human need (Berger 1967, 1977, 1992, Klemke 2000, Smith 2001, Morgan 2002, Eagleton 2007). It also reflects my agreement with Weber’s opinion that meaning is “the essential property of human action” (Brubaker 1984: 92) and with his concerns about the negative impact of Western rationalism, despite its value, on the provision of meaning (Kalberg 1980, 2005, Brubaker 1984, Schroeder 1987, Schluchter 1989). Such an approach facilitates critique, of dominant meanings assigned to depression, and exploration, of alternative meanings of depression. Meanings of depression confined to certain types of meaning (scientific meaning) provide value of a restricted nature but also rob the individual of other

meaning options. This, essentially, is the problem of meaning and depression in the contemporary West. The disagreements and variety of opinion about depression speak to the need to recognize that meaning is more than *only* diagnosis and treatment, more than *only* cause and effect.

Assigning meaning to anything can become problematic when the meaning-making process itself is not recognized as arising from specific world-views. That the meanings assigned to health and illness reflect specific historical / cultural framings is often not recognized. This not only produces problems of meaning but also problems in understanding why certain meanings achieve dominance:

Social reality is so organized that we do not routinely inquire into the meanings of illness any more than we regularly analyze the structure of our social world. Indeed, ... medical training and ... health care delivery, with its radically materialistic pursuit of the biological mechanism of disease, precludes such inquiry. (Kleinman 1988: 9)

Medicine pursues causal meanings of illness through science, whereas sociology has usefully sought to redress the imbalance fostered by medicine's focus on biology by emphasizing social and cultural meanings. However, in so doing it has accepted the medical position that depression is 'other': that it is a 'problem' to be addressed (see Chapter Six). The sociological response has merely moved the parameters of dealing with depression from the biological-scientific to the social-scientific, or to an inclusion of the social within or alongside the biological. New paradigmatic possibilities of meaning have not been created; rather meanings are tied to either biological or social-cultural causation, or to a combination of the two.

Pain, including emotional pain, is disturbing, destabilizing and demanding. An encounter with pain, with the face of the Other (the eternally unknowable), always unbalances and always requires a response; this is unlike encounters with Same, which always represent certainty, knowability and security for the self (Davis 1996). Medicine, like all of science, gives meaning by providing data, analysis, and explanation. It seeks to control and prevent pain, both physical and emotional, but it cannot impart meaning to that pain beyond scientific interpretations. Criticisms from within the medical field that "no medical model captures meaning" (Summerfield

2006c: 1154a) reflect a recognition of the limitations of scientific meaning, rather than the non-provision of meaning.

Emotional pain is something of a mystery to science, and while developments in neurobiology are beginning to unravel measurable aspects of this puzzle (Meyer *et al.* 2006), the individual search for meaning is hampered by “the modern presumption that every question can be solved in principle by rational calculation” (Morgan 2002: 312). Weber considered this situation ‘irrational’: “‘Science is meaningless’” because it cannot answer questions about how to live or what to do (Weber 1991: 143, quoting Tolstoy). The dominant medical position has effectively sequestered human emotional pain and suffering, defining it as illness, pathologizing it as depression. Suffering is regarded as “a puzzle to be ‘controlled’ if not eradicated” (Frank 1997: 146). Depression is seen as ‘other’, that which is contrapositive to ‘normality’, and as, territorially, belonging to medicine. It is therefore viewed as ‘abnormal’, requiring correction and cure. The sociological position generally accepts this fundamental approach, though it disputes aetiology. Meanings of depression are, consequently, inevitably reflective of how medicine and sociology perceive depression in the first place. Notwithstanding the fact that the medical and sociological perspectives about mental illness, generally, and depression, specifically, are not homogenous and are often quite divisive (*e.g.*, Pilgrim & Rogers 1999, Ellis *et al.* 2004a), the dominant meanings of depression are explicated through how depression has initially been interpreted as a problem to be defined and solved (the interpretative orientations).

These proffered meanings, however, do not satisfy the human need for comprehensive meaning. This is because such need extends beyond causal meanings of a medical or sociological nature to ‘other’ meanings, to meaning possibilities neither calculable nor predictable – even remaining, like Other, always unknown and irreducible. Science “itself is meaningful throughout, but on existential and global meanings it is silent” (Smith 2001: 198). Meaning furnished by Western rationalism can only ever be of a scientific nature. Weber sought in his work to investigate the tensions in the West wrought by facilitating freedom for the individual in assigning meaning according to scientific rationality at the same time as removing any chance of coherent and comprehensive meaning, such as was formerly provided by the ethical substantive rationality of religion (Kalberg 1980, Brubaker 1984, Schroeder

1987, Schluchter 1989). There is divisive opinion regarding what depression means, particularly in medicine, and there are concerns about the loss of unhappiness as a normal state, in both medicine and sociology. These reflect the problems Weber identified in Western rationalist approaches to the world operating beyond the narrow confines of science, the problems Derrida saw in the centred and exclusive nature of the Rousseauistic Interpretation, and the problems Levinas saw in the aggressive renunciation of Other.

Medicine and sociology increasingly and unquestionably provide benefits in the provision of well-researched causal meanings assigned to depression. Dissatisfaction with current approaches to depression and disagreement over a variety of issues reflect not problems with the medical and sociological meanings of depression but that these scientific meanings, being restricted by the nature of Western rationalism, form only one part of what depression can mean. There is an awareness of “the limitations of a medical system that remains rooted in a cause-cure paradigm, while little credence is given to alternative approaches”, yet doctors “continue to draw upon a medicalized discourse of depression, because this discourse is the one most readily available to them through their training” (Thomas-MacLean & Stoppard 2004: 288). It is through the ‘inconvenient voices’ (see 7.5) that the problem of meaning is particularly revealed to be a problem of rationality.

Depression, despite the contested opinions about the specifics of what it means (Summerfield 2006a, Parker 2007), is generally considered in medicine to refer to illness only, and meanings of an existential or spiritual nature are necessarily absent. However, science can only provide medical ‘facts’ and these do not assist the individual in the “search for meaning in the face of ... suffering” or the legitimization “of their pain and suffering..., medically and socially” (Bendelow & Williams 1995: 162). Moreover, in searching “for the common denominator for human beings in the minutiae of brain chemistry, or in the depleted resources of serotonin, we are robbing ourselves of our humanity” (Hansen 2004: 42). Due to growing recognition in both medicine and sociology that provision of scientific interpretations and causal explanations cannot assist existential or spiritual searches for meaning, the need to address the place of meaning in depression has been approached from a variety of positions (Hassed 2000, Shaw & Woodward 2004b, D’Souza 2007, Horwitz &

Wakefield 2007). The neglected place of meaning in suffering has specifically raised interest in theodicies and narratives (Bendelow & Williams 1995), narratives (Kleinman 1988, Frank 1997, 2000, Hydén 1997, Kangas 2001), spirituality (Swinton 2001), a sociology of suffering (Wilkinson 2005), a “pedagogy of suffering” (Frank 1997: 145), a ‘sociodicy’ of suffering (Morgan & Wilkinson 2001), and in the relationship between rationality, suffering and theodicy (Morgan 2002).

The meanings of depression developing from Western rationalist perspectives, whether medical or sociological, tend towards, utilizing Deleuzian terms again (Colebrook 2002), being ‘arborescent’ in their emphasis on linear definition, solution, and causality, whereas ‘other’ meanings developing outside the strict confines of Western rationalism tend towards a ‘rhizomatic’ multiplicity. During my examination of the depression literature and other literature, I discovered these to be salient visual representations of differences in meaning proffered by the meaning orientations (‘arborescent’) and by the ‘inconvenient voices’ (‘rhizomatic’). Nevertheless, neither sort of meaning is ‘correct’: they are merely different, providing different benefits and different possibilities. Together both the ‘voices of investigation and explanation’ (7.4) and the ‘inconvenient voices’ (7.5) provide a breadth of meaning possibilities not achievable through either alone. However, I am not establishing discrete categories, because whether a ‘voice’ is considered ‘inconvenient’ is entirely dependent on perspective and ‘inconvenient voices’ can still be concerned with causality. Rather, I am using these categories to explore the sometimes elusive sense of absence and presence of ‘meaning’ and the conflict between the ‘different meanings’ that can confound discussions of depression and meaning, but that can also facilitate an alternative approach.

## **7.4 Voices of Investigation and Explanation**

Approaches to depression in both medicine and sociology are characterized by ‘voices of investigation and explanation’. The emphasis in much of the research is on explicating the causes and processes involved in depressive illness. While opinions vary and research is not conclusive, such investigations and explanations of

depression significantly advance the knowledge base of depression. Although these approaches have been criticized in both medicine and sociology, I feel that in order to fully appreciate the complexity of meaning in the field of depression it is first necessary, despite the lack of certainty and congruency, to value the benefits of such approaches before exploring the questioning of such approaches.

It is clear from the medical literature that medicine recognizes depression to have multiple causes. For example, depression is viewed as “a final common pathway resulting from the interaction of biological, psychological, and social factors” (Peveler *et al.* 2002: 150). However, while aware of the complexity of depression, most research concentrates on the genetic and physiological causes (Belmaker & Agam 2008), such as neurochemical dysfunction of brain circuitry (Davidson *et al.* 2007, Meyer *et al.* 2006). More strongly stated, Rubinow (2006: 1305, referring to recent research) considers that due to advances in science and technology “we now know that depression is characterized by abnormalities of cell signalling, neuronal and glial survival, and brain-region connectivity and network activation”.

Establishing causal mechanisms and processes in depression is a pressing issue for medicine but, in spite of “the high morbidity and mortality associated with depression, the aetiology and pathophysiology of depression have not been precisely defined” (Insel & Charney 2003: 3167). Medical research has produced a plethora of information regarding the scientific meanings of depression. While such research has indicated neurological, chemical, and electrical abnormalities in the brain that may be associated with depression (Mann 2005) no conclusive facts have emerged. Indeed, Davidson and colleagues (2002) admit that it is not clear whether the brain abnormalities precede, co-occur, or follow episodes of depression, but believe that future research will enable clearer correlation. This is a frustrating situation for medicine. Even with increasing information about possible links between brain function and depression, none have been clearly established as directly causative, nor have the connections been fully explicated, and “none of the research has resulted in a specific biomarker or diagnostic test for depression” (Insel & Charney 2003: 3167).

In addition to the lack of certainty arising from such medical research, findings and opinions also differ. Rubinow (2006: 1305), in contrast to research by Insel &

Charney (2003), Mann (2005) and Davidson and colleagues (2002), considers neurobiological research and technological advances have now isolated the identifiable “pathological signatures of depression” in the brain. However, while neurological research has demonstrated that changes to brain chemistry and physiology may be related to depression, the context and meaning of these relationships are unclear. For example, “whether the changes observed in the hippocampus in cross-sectional studies are in fact the result of depression and stress, or whether they are the cause of certain clinical characteristics of the illness ... remains to be resolved” (Ebmeier *et al.* 2006: 156). Keller (2003) refers to some studies that show a relation between hippocampal volume and depression, with reduced volume correlating to longer periods of depression. Conversely, however, Keller (2003: 3155) also points to other studies that have “demonstrated no structural changes in the brains of patients with depression”. Thus, while neuroimaging has provided much information and data that link brain functioning to depression the research findings are ambiguous and “have not yet determined the clinical consequences of these findings” (Keller 2003: 3157).

Much research is also devoted to genetics, but as with research into possible biochemical causes of depression the findings are strongly suggestive but not conclusive. There “is no doubt that genetic factors have an important role in the aetiology of depression” (Ebmeier *et al.* 2006: 154), something confirmed by inter-generational studies (Weissman *et al.* 2005). The area of genetics is viewed as offering great potential for eventually determining the genetic cause(s) of depression (Barondes 2003, Bennett 2007), even though “vulnerability genes for depression have not been identified” (Insel & Charney 2003: 3167). Medicine does recognize, however, that there is a causal link between biological and environmental factors. Negative childhood experience has been consistently associated with development of depression, but precisely how “a genetic predisposition interacts with adverse early-life experience to alter brain development and lead to major depression remains unclear” (Mann 2005: 1819).

There is no doubt that medical research has facilitated a greater understanding of some aspects of the relationship between brain function and physiology and depression. The understanding of depression “has evolved from a vague notion of



mood and emotion to a differentiated understanding about how emotional and motivational changes interact with information processing in patients' brains" (Ebmeier *et al.* 2006: 158). Nevertheless, while the medical position acknowledges the role of environmental factors (negative early life experiences, for example) in the aetiology of depression, research is focussed heavily on identifying biological causative factors. This has probably contributed to a wide public perception that depression is a 'biological illness'. This focussed emphasis on the biological determinants of depression has resulted in little focus on demographic causative factors, such as gender, poverty, and ethnicity, or social causative factors, such as major life events of the death of a partner or child, unemployment, or divorce. However, research has demonstrated the link between major stressful life events and depression and its use in predicting subsequent depression (Kessler 1997, Monroe & Harkness 2005). Other research reinforces "arguments for the importance of preventative strategies that will enable young Australians to avoid the negative life trajectories that are associated with depression" (France *et al.* 2004: 236).

As with medical research, sociological research is largely focussed on investigation and explanation. Such research is directed at both explicating problems with the dominant medical paradigm and emphasizing the importance of social-cultural factors. For example, research demonstrates that meaning becomes problematic in its reduction to genetic causality (Conrad 1999) and to screening for genetic abnormalities (Cunningham-Burley & Kerr 1999). Meaning is both problematic and compromised in the medicalizing of sadness as depression (Horwitz & Wakefield 2007). Disempowerment is explored as of primary aetiological significance in any sociological understanding of depression and the risk of depression (Ylipaavalniemi *et al.* 2005). The relationship between diagnostic criteria and depression (Moncrieff & Crawford 2001, McPherson & Armstrong 2006), gender and depression (Nazroo 1998, Griffin *et al.* 2002), and ethnicity and depression (Coker 2003, Inaba *et al.* 2005) are examples of the wide array of sociological factors examined in terms of depression that provide important information about social causative factors involved in what is diagnosed in the West as depression.

Emphasis in sociology is also placed on the importance of patient narratives in revealing the complexity of achieving an understanding of depression because, even

if a narrative develops around a “core explanation”, a “single explanation does not necessarily suffice in the sense-making process ... [and] does not structure the entirety of depression experience” (Kangas 2001: 89). This awareness of the complexity and diversity of the depression experience is also evident in other research (Karp 1996, 2001, 2007) that focuses on giving voice to the stories of those experiencing depression and of their families, and of subsequently discerning in these stories some general patterns and themes about the dimensions of depression in society. There is also a variety of other interesting sociological research directions that provide additional facets to our understandings of depression. For example, research examining volunteering (Musick & Wilson 2003: 259) revealed the value of volunteering in lowering the incidence of depression levels for older people and that volunteering for religious causes was “more beneficial than volunteering for secular causes”. Sociological research adds considerably to the broadening of our understandings of what depression means, to the importance of non-biological factors, and to causal links other than those provided by the medical profession.

One area of mutual concern to both medicine (Hassed 2000, Smith *et al.* 2003, D’Souza 2007, Koenig 2007) and sociology (McGuire & Kantor 1987, McGuire 1990, Idler & George 1998, McClean 2005) that also counters the prevailing emphasis on causality, or at least alters the emphasis, is the place and importance of spirituality. Religious / spiritual meaning, in its broadest sense, is often central to how an individual comes to understand any illness, particularly chronic illnesses like depression. The human need for “theodicies” to give meaning to illness is not part of the medical paradigm and, because “illness etiologies in Western medicine typically deal with proximate causes”, they fail to deal with existential questions of meaning (Freund & McGuire 1995: 139). Spirituality tends to be accepted only as “‘background noise’ ... [and] is assumed not to bear any real relationship to the central therapeutic task” (Swinton 2001: 41). Interest in the relationship of spirituality / religion to the meaning of depression receives considerably less emphasis than other areas of research in either medicine or sociology. This interest does, however, reflect the complexity of meanings assigned to depression and mental illness from sociology and medicine that extend beyond emphasis on the causal factors of depression, or are concerned to offer alternative perspectives on meaning other than, or in addition to, causality.

Medical and sociological investigations and explanations of depression furnish the considerable benefits possible through the application of Western rationalism. Weber was acutely aware, however, of both the values of Western rationalism in facilitating scientific explanations of the world and its deficits in restricting meaning (Weber 1991). As such, the contemporary Western framing of depression is both enhancing and impoverishing: enhancing, because it provides useful rational-scientific evidence concerning depression, but also impoverishing, because it restricts meanings of depression within scientific parameters. In a Derridean sense, these issues reflect the value of a centred interpretation of life and the world that is afforded by the Rousseauistic Interpretation. It is not possible to live without a centred interpretation (Derrida 1978), but knowing that the centre exists facilitates recognition when both interpretations of the world and the meanings assigned to that world have been centred. Awareness of what meanings may lay beyond a centred perspective, and that they, too, may have value, is then facilitated.

## **7.5 ‘Inconvenient Voices’**

Within both medicine and sociology, in addition to ‘voices of investigation and explanation’, are to be found ‘inconvenient voices’ that question the contemporary framing of depression. For example, in his criticism of Ebmeier and colleagues (2006), Summerfield (2006b: 1235) points to the lack of a consideration of “everyday misery or unhappiness, as if the discourse on depression was self-evidently a domain apart”, sentiments also expressed in much sociological research (Shaw & Woodward 2004b, Horwitz & Wakefield 2007). Through their questioning, such ‘inconvenient voices’ add another dimension to the range of meanings available for depression and also aid in understanding the restrictive influence of Western rationalism on meaning.

Following Weber’s (1991: 147) thoughts on the role of the teacher in developing in students an awareness of “inconvenient facts”, I assign considerable importance, as previously discussed, to the work of sociologists in developing an awareness of ‘inconvenient voices’. These ‘inconvenient voices’ compel attention to the meanings

generally assigned to depression in contemporary Western culture, due to the focus on causality in the meaning orientations, and to the implications this raises for the possibility of other meanings of depression. While such ‘inconvenient voices’ are found in both the medical and sociological approaches to depression, as well as in other fields, medicine is particularly plagued by them. This probably reflects the fact that it is medicine that largely determines the West’s response to depression and the meanings assigned.

The dominant ‘party opinion’ of medicine is unsettled from within and without by ‘inconvenient voices’ and the facts and ideas they raise that draw attention to problems with, and shortcomings of, the Western rationalist foundation of the medical paradigm of depression. These ‘inconvenient voices’ demonstrate the restricted nature of meaning based on the emphasis in Western rationalism on scientific interpretation and causality. Predominantly, sociological research contributes to efforts to widen understandings of depression, to demonstrate problems within the medical approach, and to suggest alternative approaches and meanings. These ‘inconvenient voices’ arise from some level of disenchantment with the medical paradigm of depression and foster alternative considerations of depression. In addition, there are ‘inconvenient voices’ from a variety of other sources that translate into little and large question marks unsettling the contemporary Western paradigm of depression and the meanings of depression that are dispensed as the *only* reputable meanings.

The value, in a Weberian sense, of such ‘inconvenient voices’, and the inconvenient facts and opinions they raise, is in maintaining an awareness of *why* we think what we think, and in facilitating a deeper cognizance for the multiplicity of meaning possibilities. The ‘inconvenient voices’ strengthen the individual freedom to choose, something Weber saw as a positive result of Western rationalism. From a Derridean perspective, these ‘inconvenient voices’ can be Nietzschean; and some are Nietzschean *par excellence*. Whether strongly inconvenient or quietly inconvenient, such voices, nevertheless, reveal the generally centred nature of the meanings assigned to depression, both medical and sociological, and the existence of other meanings. In a Levinasian sense, the ‘inconvenient voices’ speak in some way to recognition of the reduction of the faces of Other into Same, even if rarely

demonstrating complete respect and concern for the relationship between Same and Other or for the essential unknowability and uncontrollability of Other.

In medicine and sociology, ‘inconvenient voices’ demonstrate their inconvenience in different ways, for different reasons, and in different intensities. Some ‘inconvenient voices’ speak softly about a few issues they consider need tweaking or altering; others are vocal about a complex of issues and suggest broad changes; and still others bellow about the necessity of entirely changing existing approaches. In addition, there are ‘inconvenient voices’ from other fields that also niggle and gnaw at the meanings attributed to depression in the modern secular West. All such ‘inconvenient voices’, to a greater or lesser degree, question the meanings that are currently proffered. They suggest variously small or radical changes, directly pointing to or hinting at other meaning possibilities excluded from consideration by the contemporary Western framing of depression. It is through these questioning perspectives that the meaning of depression in the contemporary West is both gently and forcefully probed, pointing to ‘a place and a space’ where tears might still dwell in the contemporary West. Also to be discovered in these ‘inconvenient voices’ are reminders and rumours of the importance and value in suffering of relationship and that causality does not constitute the entirety of the meaning possibilities of depression.

### **7.5.1 Medical ‘Inconvenient Voices’**

Within the medical literature there are a growing number of ‘inconvenient voices’ challenging the medical approach to depression, pointing to disagreements and uncertainties, demanding that depression needs ‘rethinking’, suggesting alternative approaches and meanings, and even calling for a closer relationship with other disciplines. For example, Summerfield (2006b, 2006c) has been vocal in his criticism of the medical paradigm of depression that is interested in biological interpretations and scientifically based facts but not meaning. Boughton and Street (2007), in stressing the complexity of gender issues in depression, point to recognition that psychiatric guidelines influence understandings of depression and suggest a change of perspective from intrapsychic processes to interpersonal processes. Such examples

of medical ‘inconvenient voices’ are published in all the leading medical journals, and I have detected no sense that some journals avoid or restrict publication of such material.

Concern is also expressed in the medical literature about the lack of a place for the spiritual in mental health (Culliford 2002a, 2002b, Swinton 2001), about the bias of RCTs in EBM and of drug companies in the testing of antidepressants (Dewhurst 2004, Ellis *et al.* 2004a, Geddes & Cipriani 2004), and about the medicalization of sadness (Pilgrim & Bentall 1999, Dowrick 2004, Blazer 2005) that now verges on “disease mongering” (Moynihan *et al.* 2002: 886). In their discussions of the medicalization of misery as depression Pilgrim and Bentall (1999: 272) suggest that a “more holistic understanding would attend to the social determinants of misery *and* would involve exploring the patient’s individually attributed meaning”. Even among those supportive of psychiatry is recognition of the existence of disagreements. For example, there are disagreements about diagnostic guidelines and the effects of changing parameters (Ellis *et al.* 2004a, Kleinman 2004, Parker 2004a, 2004b, 2008a, Timimi 2004, Ebmeier *et al.* 2006). There are also differences of opinion about whether the role of the family of the mentally ill in diagnostic processes are of benefit or not (McGrath 2002, Parker *et al.* 2003, Highet *et al.* 2004).

Other ‘inconvenient voices’ include those expressing recognition of the need to improve environmental factors to reduce depression (Burns *et al.* 2002), an awareness of the influence of different cultures (Patel *et al.* 2001, Kleinman 2004), and criticism of diagnostic guidelines in terms of gender (Brownhill *et al.* 2005) and age (Chew-Graham *et al.* 2004). The placebo effect is also viewed as a controversial subject (Harrington 1997, Scott 2000, Parker 2004b, Wampold *et al.* 2005, Lenzer & Brownlee 2008), and the possibility of harnessing multiple placebo responses in clinical practice (Price *et al.* 2008) raises questions about standard treatment responses. In addition, the apparent efficacy of the placebo effect over, or equal to, medication raises questions concerning the biological basis of depression, and therefore what meanings can be attributed. There is also concern about the over-use of, and reliance on, pharmaceuticals and the expectations this raises in terms of how depression is understood (Moncrieff & Kirsch 2005). Dowrick (2004) is highly critical of prevailing beliefs about depression, explores factors other than medicine

that have contributed to our present misunderstandings about depression, and concentrates his approach to depression on narratives of the individual within a relational framework. In a similar vein, Blazer (2005) takes a sociological stance and calls for a new social-psychiatric approach to depression, and Bell (2005) explores the medicalization of human sorrows.

These medical ‘inconvenient voices’, and the facts and opinions they raise, can be highly critical and extensive (*e.g.*, Dowrick 2004, Blazer 2005), or highly critical and short (*e.g.*, comments by Hassed 2000, Dewhurst 2004, Summerfield 2006a, 2006b, 2006c), or merely partially critical and concerned (*e.g.*, Geddes & Cipriani 2004, Ebmeier *et al.* 2006). Yet, all such voices serve to remind us that the Western rationalism that produces scientific causal approaches to depression is not without problems and shortcomings or that there may not be other ways to approach depression or other meanings to discover. Many of these ‘inconvenient voices’, indeed perhaps most, in a sense only tinker or re-direct attention towards depression from a slightly different angle in an effort to develop different interpretations and meanings, and thus they still function essentially from a Western rationalist paradigm. That is, they present variations on a Rousseauistic interpretative position instead of presenting Nietzschean interpretative possibilities. Thus, while not exactly inclusive of a broad range of meaning possibilities, at least there is an extension of the possible meanings made available.

Viewed corporately, however, their presence is a powerful indicator that the existing Western framing of depression is limited, and recognized as such. In other words, these ‘inconvenient voices’, while not disturbing radically the medical paradigm of depression or the causal meanings it produces, do seriously question them. Indeed, the work of those such as Dowrick (2004) and Blazer (2005), while not Nietzschean in a Derridean sense, do far more than seriously raise questions; they cogently demand a ‘re-thinking’ of depression and the interpretations and meanings currently forthcoming from the dominant medical paradigm of depression, and they suggest alternatives. As such, the exclusivity that tends to characterize the Western framing of depression in terms of interpretation and, therefore, meaning is manoeuvred, on the line between exclusivity at one end and inclusivity at the other end, towards less exclusivity and greater inclusivity, but, in some senses, only marginally. Such is the

pervasive and potent influence of Western rationalism that perhaps to expect anything more from medicine in its approach to depression is simply not possible at the present time.

There seems to be a difficulty that medicine has of embracing real inclusive change in its approach to depression in terms of interpretation and meaning, despite recognizing that there are gaps and uncertainties with current knowledge and the application of that knowledge. This problematic is clearly seen in how medicine seeks to deal with these recognized difficulties, inconsistencies, and disagreements concerning interpretation and meaning by its emphasis on, and belief in, future research. Again, while not embracing inclusivity, there is clearly a concern with the restricted and exclusive nature of Western rationalism in terms of how depression is interpreted and what meanings are assigned.

Nevertheless, future research about depression tends to concentrate on improving current approaches (Insel & Charney 2003) and proceeds within scientific parameters and on the premise that depression is a mental illness caused by neurobiological disorders or abnormalities. For example, it is hoped that future research may yield more efficacious types of pharmacological treatments with less side-effects and short-comings (Norman 2006), individual tailoring of drug treatments through improved sub-typing of depression (Mann 2005), and greater understandings of the neurobiological abnormalities in brain circuitry associated with depression and emotion (Davidson *et al.* 2002). Thus, human emotional suffering is still largely reduced to chemical problems to be rectified by chemical treatments. Science can be very useful in providing explanations and information about abnormalities in brain circuitry and the role of drug treatments, but this approach provides only one meaning of depression. What are absent from much of this anticipated future research is not only research into non-medical approaches to depression but also a quantitative ‘re-thinking’ of depression that facilitates an inclusive embrace of alternative meanings. It is difficult to currently foresee how the medical profession could substantially achieve any greater inclusivity of alternative interpretations and meanings to those currently promulgated. However, there are some (*e.g.*, Kleinman 1988, Dowrick 2004) who promote a relational model of medical practice and education that is centred on meaning and other ways of understanding depression.



The relationship between medicine's scientific approach and meaning is problematic in that it decides what constitutes illness and it determines treatment. This type of problem seriously concerned Weber (1991) because the application of scientific rationality beyond its narrow parameters was dangerous and also 'irrational'. For example, earlier versions of the *DSM* classified homosexuality as a type of sexual deviation (Short *et al.* 1993): in the medical paradigm, the meaning of homosexuality as abnormal was dependent on how homosexuality was interpreted and what diagnostic criteria were developed and used. Similarly, the meaning of depression as an illness is dependent on the medical interpretation of depression and the diagnostic criteria created and applied. The concern in both medicine and sociology about the medicalization of normal sadness as depressive illness (Pilgrim & Bentall 1999, Shaw & Woodward 2004b, Bell 2005, Summerfield 2006c, Horwitz & Wakefield 2007) is indicative of a problem with the meaning that medicine assigns to depression. More than physical illness, ailments concerning the mind and emotions present a difficult territory for medicine to negotiate, not because it considers such areas beyond its scope but because such areas are beyond the scientific causal emphasis and focus of Western rationalism. As such, the medical approach to depression, its interpretations and meanings, cannot but be exclusive, despite the agitations and movements towards some sort of expansion and inclusivity.

### **7.5.2 Sociological 'Inconvenient Voices'**

In the sociological literature, as with the medical literature, many 'inconvenient voices' point to a wide variety of problems with the medical approach to depression, and to other socio-cultural aspects viewed as important when considering how to interpret depression and what depression means. For example, specific concerns are raised about promoting the profession of psychiatry through use of mental illnesses such as depression and the impact this has on diagnosis and treatment (Moncrieff & Crawford 2001, McPherson & Armstrong 2006). The role of the media is explored in determining the meanings of depression (Rowe *et al.* 2003) and suicide (Coyle & MacWhannell 2002) and the difficulty of resisting dominant depression-suicide discourses (Bennett *et al.* 2003). Other research examines the complex relationship between gender and depression and its treatment (Bracke 2000, Blum & Stracuzzi

2004, Metzl & Angel 2004, Curry & O'Brien 2006) and the role of ethnicity in depression (Coker 2003, Karasz 2004, Kokanovic *et al.* 2008). In particular, the powerful impact of cultural background on understandings of depression is revealed in a study of Latvian psychiatry (Skultans 2003: 1430) in which it was reported that a patient, on asking if she would be cured of her depression, was told by the psychiatrist that “[w]e should not spit in God’s eyes. We can treat but we cannot cure”, meaning that “[o]ne should be grateful for what one is given and not ask for more”. Such an answer, in its contrast to the Western psychiatric emphasis on causation and treatment, reveals the cultural framing of Western medicine and the subsequent difference in the type of meanings attached to depression.

Sociological research has also considered the link between diagnosis, treatment, and perception of mental illness and depression and social status (Olstead 2002, Sleath & Shih 2003, Zimmerman *et al.* 2004, Lincoln 2006), the link between depression and position in the work place (Ylipaavalniemi *et al.* 2005), and the emphasis on individual responsibility for health and the avoidance of illness (Gattuso *et al.* 2005). The issue of personal identity when medication alters the personality is raised by Barr and Rose (2008) in their exploration of public ambivalence to antidepressants. In sociology, considerable emphasis is placed on researching the medicalization of sadness as depressive illness (Shaw & Woodward 2004b, Horwitz & Wakefield 2005), the value of patient narratives (Karp 1996, 2007, Kangas 2001), and discussions concerning how modernity itself may be causing depression (Kangas 2004, Shaw & Woodward 2004b).

Such ‘inconvenient voices’, as with the medical ‘inconvenient voices’, do not so much re-locate discussions about the meanings of depression as extend the possibilities and rigorously highlight problems, inconsistencies, and difficulties with the current dominant paradigm. There is, then, not so much inclusivity as a broadening of what is included in the exclusivity of how depression is currently viewed in the West. However, the inclusion of meanings other than those determined by either medicine or sociology, still tends to be restricted by Western rationalism that focuses attention on matters of scientific-rationalist causality. It is for this reason that some voices are both inconvenient to the dominant medical paradigm of depression while at the same time revealing a concern with causality. For example,

research explicating how sadness has been medicalized as depressive illness (Horwitz & Wakefield 2007) is both inconvenient to the medical framing of depression as well as concerned with causality. Similarly, research into social status and work (Zimmerman *et al.* 2004) or influences on the prescribing of antidepressant drugs (Sleath & Shih 2003) is inconvenient to medicine because the strict biological basis of depression diagnosis and treatment is challenged by the focus on social factors, but is also concerned with causality because such research is focussed on non-biological factors involved in depression and its treatment. The value of these types of research, in both sociology and medicine, is that a vast array of causal factors and issues are explored and documented in both biological and social areas. Such monumental and extensive research cannot help but improve and extend knowledge and understanding of depression.

In addition, while not directly concerned with depression, there are many other areas of sociological study that nevertheless impact on our understandings of depression in the contemporary West and approaches to it and, most importantly, what meanings are possible for depression. These would include: studies concerned with suffering, meaning, theodicy and modernity (Morgan 2002, Morgan & Wilkinson 2001, Wilkinson 2005); research about the problems with EBM (Quah 2003, Filc 2004, Barry 2006, De Vries & Lemmens 2006, Goldenberg 2006); illness narratives (Frank 1991, 1997, 2000, Hydén 1997, Ezzy 2000, Bury 2001, Lawton 2003, McClean 2005); the relationship between spirituality / religion and quality of life (WHOQOL 2006); disability theory and empowerment of the mentally ill (Mulvany 2000, Lester & Tritter 2005); chronic illness and pain (Strauss 1981, Corbin & Strauss 1988, Lupton 1994, Bendelow & Williams 1995, Toombs *et al.* 1995, Conrad & Bury 1997, Williams 2000a); shyness (S. Scott 2005, 2006); happiness (Shaw & Taplin 2007); concern with emotions and reason (Williams 2000b); the value of otherness, possibility, and multiplicity as opposed to resistance, certainty, and repetition (Fox 1998); and problems with mind / body split (McGuire 1990, Bendelow & Williams 1995) or body / self split (Davidson 2000).

To extrapolate on just some of these examples will illustrate their value and import in terms of meaning and depression. For example, Goldenberg (2006: 2630) considers that one of the main problems with EBM is that, in restricting evidence to objective

and scientific criteria, it does not give legitimate weight to patient's self-understanding and experience as evidence and is "not conducive to ... questions of meaning". To rectify these problems with the strict scientific base of EBM that is so unfavourable to questions of meaning a phenomenological approach is needed to "flip EBM's hierarchy of evidence on its head", thereby enabling a focus on issues of meaning (Goldenberg 2006: 2629-2630).

Similarly, in Frank's (1997) discussion of different illness narratives he explores the relationship between illness and possibilities of meaning. The restitution narrative, for example, is preferred over the chaos narrative by medicine as it conforms to the model of 'getting sick', followed by 'being cured', and 'returning' to the world. Whereas, the "anxiety that the chaos story provokes in others leads to the standard clinical dismissal of chaos stories as documenting 'depression'" (Frank 1997: 110). Likewise, the quest story, which accepts illness as a calling, does not sit comfortably with medicine either, as it involves the ill person on a quest as 'hero', journeying 'through' illness as a witness of 'woundedness'; and

[l]ike most returning heroes, he finds that others do not want his woundedness; they do not want reminders of their own wounds. But to those who know they are wounded ... [each quest story] is an opening that heals. (Frank 1997: 185)

This concern to embrace 'other', rather than to resist it, is also explored by Fox (1998) in his discussion of the value of a postmodern analysis of health and illness. In its emphasis on a "*responsibility to otherness*", in which there is a "rejection of a will to mastery, and the substitution of an identity-seeking discourse with a celebration of what is other, different and diverse", Fox (1998: 21, quoting White) describes such a postmodern approach as characterized by "a postmodern ethos ... of 'grieving delight': grief as our response to suffering, delight in the diversity of our humanity".

Also concerned with emotions, Williams (2000b) cautions against the equating of happiness with mental health and of unhappiness with mental illness. Further, Williams (2000b) warns that the risk in sociology of not critically engaging with the problems of emotional states and mental health and illness is the perpetuation of the

mind / body and emotion / reason dualisms. This would result in the sociology of mental health becoming “yet another ‘straight-jacket’, wittingly or otherwise, in keeping with two centuries of ‘unreasonable’ Western thought and practice” (Williams 2000b: 575). Finally, in their discussions about pain, Bendelow and Williams (1995) comment, echoing Weber’s (1991) views on science operating beyond its narrow boundaries, that the medical domination of approaches to pain has been to its detriment. It has not only “severely limited the conceptualisations of pain by creating false dichotomies, but it has also given medicine the impossible burden of trying to relieve conditions which stretch beyond the realms of its capabilities” (Bendelow & Williams 1995: 160). These few examples indicate some of the alternative ideas that, in application to depression, could lead to a greater inclusivity of possible meanings than are generally found in the dominant causal-based sociological research into depression.

### **7.5.3 Other ‘Inconvenient Voices’**

There are also ‘inconvenient voices’ to be found in material from other areas that provide great potential for expanding the meaning possibilities of depression. For example, from the area of religion and spirituality these include: an Eastern religious approach to anxiety and pain in the modern world (Watts 1997); explorations of the relationship between sorrow and hope (St. John of the Cross 1979, Caygill 2003, Chittister 2003, Teresa 2007, Van Biema 2007) and between spirituality and pain (Heidish 2001, Moore 2002, Chryssavgis 2004, May 2005, Rohr 1996); a study of hermeneutics and religion in the contemporary world and the place of hope and meaning (Tracy 1987); and discussions concerning modernity and spirituality (O’Donohue 2000), and modernity and religion (Berger 1967, 1969, 1992). Other areas of valuable material include the loss of the tragic vision of the West (Coffey 2005); coping with life’s pain (Moore 1994, 2004) or with cancer and disability (Newell 2003, 2008, Newman & Newell 2007); the relationship between wisdom and grief (Greenspan 2003); problems with modernity and reason (Saul 1992, Carroll 2004); the place of the individual, individualism and cultural changes in modernity (Honneth 2004); exploration of meaning (Klemke 2000, Eagleton 2007); and the West’s relationship with happiness (McMahon 2006). Moreover, there are some

‘inconvenient voices’ (Del Nevo 2008, Wilson 2008) that reject the Western obsession with happiness and applaud the melancholic, or that consider modern Western society itself may be causing depression (Hansen 2004).

Expanding on several of these will demonstrate their worth and the alternative insights they provide regarding depression and meaning. For example, a perspective on how meaning is assigned is seen in the move towards inclusion of the disabled at the same time as medical and technological advances screen for abnormalities in order to rectify them. While disability is accepted, its meaning is tied to abnormality. This creation of disability as ‘other’ views brokenness as having no value when in fact to a disabled person their disability may be the source of some of their “best skills and life experiences” (Newell 2003: 2). Often the perspective on disability and illness, including from the disabled themselves, is characterized by an emphasis on rising above the tragedy of their disability (Newell 2008) and being positive and victorious over human brokenness rather than accepting this ‘other’ as a valuable gift not to be fought against or risen above (Newman & Newell 2007). Such acceptance and valuing of suffering and the chaos it brings leads to entirely different meanings than those provided by resistance to suffering through emphasis on causality.

From a Christian religious perspective Chittister (2003: 84, 90) writes of the value of losing certainty and the experience of suffering in which the scars from the struggle can become gifts: “the wellspring that is our innermost selves” is valuable because there “is beauty in the dark valleys of life”. In a similar vein, Moore (1994: 138), with an eclectic background in Christianity, psychotherapy, and religion, seeks specifically not to designate depression as the ‘other’, seeing it is very much a part of what it means to be a human being because the grey emptiness of depression evokes “an awareness and articulation of thoughts otherwise hidden”. It is melancholy that “gives the soul an opportunity to express a side of its nature that is as valid as any other, but is hidden out of our distaste for its darkness and bitterness” (Moore 1994: 138). For Moore (2004: xix, 311), the dark nights of the soul “may be profoundly unsettling, offering no conceivable way out”, and what is needed is a

spiritual response, not only a therapeutic one. It pushes you to the edge of what is familiar and reliable, stretching your imagination about how life works and who or what controls it all. The dark

night serves the spirit by forcing you to rely on something beyond human capacity. It can open you up to new and mysterious possibilities.... The dark night is the ... deep, dark discovery of roots and cellars, the opposite of enlightenment, but equally important and equally divine. It is the pulling apart of meaning so that mystery can be revealed.

Also interested in the value of the melancholic, Wilson (2008), an academic whose background is in literature and psychology, expresses deep concern about the emphasis in society on happiness, about the dangers associated with this, and advocates embracing the depressive side of our natures. Wilson (2008: 149) asks why, given the virtues of melancholia as the source of creativity and inspiration,

are thousands of psychiatrists and psychologists attempting to 'cure' depression as if it were a terrible disease? Obviously, those suffering severe depression, suicidal and bordering on psychosis, require serious medications. But what of those millions of people who possess mild to moderate depression? Should these potential visionaries also be asked to eradicate their melancholia with the help of a pill? Should these possible innovators relinquish what might be their greatest muse, their demons giving birth to angels?

Finally, McMahon (2006: 13), an historian, examines the Western history of happiness in which he sees the Enlightenment as pivotal in altering the long-standing concept of happiness as transcendent beyond the "merely human". McMahon (2006: 470) considers this concept to have developed into an obsession with happiness in this life, noting that "it is not difficult to imagine what Nietzsche, Schopenhauer, and Freud might make of the many studies that seem to indicate a precipitous recent rise in depressive disorders in cultures devoted to the pursuit of happiness".

These 'inconvenient voices', in providing a wide array of approaches to understanding the human condition from both religious and secular perspectives, offer fascinating and insightful alternative points of view on depression and meaning. Even art, music, and literature have much to say about suffering, our experiences of it, and the meanings we attribute to it. All such voices, if not directly inconvenient to the medical or sociological positions on depression, are certainly not supportive of a scientific-rationalist approach to life and suffering. They point to other ways of seeing and experiencing life, and in so doing provide alternative ways of considering

human sadness specifically, and suffering generally. These other ‘inconvenient voices’ move far closer to an inclusivity of alternative meanings than is to be generally found in either the medical or sociological literature.

Perhaps the most potent written source of ‘inconvenient voices’ in terms of an inclusivity of meaning possibilities for depression is poetry. For poetry can be truly Nietzschean in character, in terms of Derrida’s concept of a multiplicity of possible meanings afforded by the non-centred Nietzschean Interpretation, and truly Levinasian in character, in terms of a focus on the relationship between Same and Other. There is possibly nothing more subversive of Western rationalism and scientific rationality, of logocentrism in the West, and of the impulse to always reduce Other to Same, than poetry. In his ideal Republic, Plato wanted to banish poetry, among other things, because it was against “the law and reason of mankind”, warning that to go against this would mean a State ruled by “pleasure and pain” (Parini 2008: 3). If poets really are “the legislators of the unacknowledged world” (Parini 2008: 178, quoting George Oppen) this perhaps explains the danger they can pose to Western rationalism, and the dangers Plato saw in them.

The link between creativity and depression extends back to the Ancient Greeks and Aristotle’s question in the *Problemata*: why is it

‘that all men who have become outstanding in philosophy, statesmanship, poetry or the arts are melancholic, and some to such an extent that they are infected by the diseases arising from black bile?’ (Radden 2000: 57, quoting Aristotle or a follower of Aristotle)

Medical research today dismisses such a positive association between creativity and depression, pointing to findings that indicate a reduction in creativity with mood disturbances (Baas *et al.* 2008). Nevertheless, the link between creativity and melancholia is still argued for (Wilson 2008) and, interestingly, eighty percent of poets are reported to have mood disorders (Berlin 2008).

While many poets confirm such findings (the negative impact of depression on their creativity), there are others who have found value in their depression and an important relationship with the depressive part of themselves (Berlin 2008). For



example, Lewis (2008: 22) considers her depression to be an angel, bringer of both pain and gifts, and writes profoundly of the suffering wrought by her ‘Angel of Depression’: “Oh yes, I’m broken but my limp / is the best part of me. And the way I hurt”. Similarly, Budbill (2008: 80, 90) also writes of his “Angel of darkness, Angel of depression, dark Angel / of life” and looks on his depression not as “periods that are to be fought against and resisted, but as dormancy periods, gestation periods, to be accepted, given in to, welcomed”. In addition, Rilke once famously stated: “‘If I lose my demons, I will lose my angels as well’” (Berlin 2008: 4).

This embracing of depression, this decision not to resist it in some way, not to search for rational causality and certainty, but to accept it and the chaos it brings, to even welcome it and to value a relationship with it, is totally anathema to the contemporary Western framing of depression. In the ‘The Duino Elegies’ Rilke (1966: 170, 204) writes:

Every Angel is terrible, Still, though, alas!  
I invoke you, almost deadly birds of the soul ....

Some day emerging at last out of this fell insight,  
may I lift up jubilant praise to assenting Angels!  
May not one of the clear-struck keys of the heart  
fail to respond through alighting on slack or doubtful  
or rending strings! May a brighter radiance stream from  
my streaming face! May inconspicuous Weeping  
flower! How dear you will be to me then, you Nights  
of Affliction! Why did I not, inconsolable sisters,  
more kneelingly welcome you, more loosenedly render  
myself to you loosened hair? We wasters of sorrows!  
How we stare away into sad endurance beyond them,  
trying to foresee their end! Whereas they are nothing else  
than our winter foliage, our sombre evergreen, *one*  
of the seasons of our interior year, – not only  
season – they’re also place, settlement, camp, soil, dwelling.

It is contrary to the majority of opinion, if not all opinion, in both medicine and sociology that emotional suffering could be viewed as the ground of being and that visitations of depression be not resisted and wasted but joyously welcomed and valued. Such ‘inconvenient voices’ proffer a radically alternative sense of depression and what it could mean. In their inclusive approach to depressive moods, there is a total emphasis on relationship and a complete disinterest in the causality of

depression. Assigning meaning to depression represents the notion that “human beings confer meaning onto *everything* in their worlds”, but such insight is achieved only after the continued presence of pain has been internalized (Karp 1996: 128). Depression, as a marginal situation, is “characterized by the experience of ‘ecstasy’ (in the literal sense of *ek-stasis* – standing, or stepping, *outside* reality as commonly defined)” (Berger 1967: 43). The idea of the individual “stepping outside..., alone, to face the night” (Berger 1963: 171) is not only entirely adverse to the dominant paradigm of depression but reveals how restrictive are the possibilities of meaning when confined to within the narrow parameters of causality.

#### **7.5.4 The Value of ‘Inconvenient Voices’**

Weber considered that in the West, because of the dominance of Western rationalism and the emphasis on scientific rationality, the values inherent in substantive rationality would be only found “‘at the edges’” (Kalberg 1980: 1176) and expressed in small private groups (Weber 1991: 155) and voluntary associations (Seidman 1984, Kalberg 1980). In addition, Weber also considered that art, unlike science, is “never surpassed; ... never antiquated” (Weber 1991: 138). I suggest that together these two insights, when combined with Weber’s emphasis on the importance of “inconvenient facts” (Weber 1991: 147), provide a validation of the value and importance of ‘inconvenient voices’ arising from the arts in their provision of alternative meaning possibilities in Western modernity, including for depression.

Today, ‘inconvenient voices’ such as Rilke’s are crucial in their provision of meaning possibilities that are closed off by the force of Western rationalism in the meaning-making process. They provide ‘a place and a space for tears’, even if it is ‘at the edges’. Spanning some four millennia the concerns with, and approaches to, suffering seen in the words of Job and Rilke reflect Weber’s (1991) opinion that art is always valid and fulfilling as a potential source of meaning: the meanings assigned to suffering reflect continuity and remain relevant. The focus of Job and Rilke on relationship in suffering, as opposed to causality as represented by Job’s friends and most opinion in medicine and sociology, reflects not only the long-standing tension between relationship and causality in suffering but the tendency of the latter towards

domination of the former – except, that is, in a few ‘inconvenient voices’. These are the voices of those who have not only “unawares entertained angels” (Hebrews 13: 2), but, becoming aware, have chosen, knowingly, to welcome these angels, however dark, however terrible, because they are, nevertheless, angels still. As the face of the Other they are respected, not attacked:

Sometimes it takes darkness to bring us alive.... This is exactly what John of the Cross is saying: learn to be at home in the dark. Do not run away from it. Do not fight it, do not even try to understand it. Embrace it; the night has eyes. (McCaffrey on Coffey 2008c: 8)

This is why these ‘inconvenient voices’, in having “discovered that suffering is not futile and ... not meaningless” (Wright on Howard 2008: 16), function as the carriers of such alternative meanings and why they are so important. It is also why Plato, who sought causality of suffering, was right to view such voices as dangerously subversive of order and control and reason. These modern ‘inconvenient voices’ speak of value and beauty in suffering, despite the pain, as did the ancient Greek tragic poets and Aristotle some two-and-a-half thousand years ago. Many of the ‘inconvenient voices’ concerning depression raise issues and point to problems, uncertainties, or issues with the contemporary Western framing of depression. However, most are so constrained by Western rationalism that, although exploring other possible meanings of depression, they are simply not able to venture very far towards the frightening and enriching alternative meaning possibilities of depression that some have discovered and that echo down the centuries in Western literature.

Today, this dynamic tension between relationship and causality oscillates strongly in one direction. The result is that an individual visiting a doctor for depression will receive, in all likelihood, a prescription for antidepressants, not a prescription to read the words of Job or Aristotle, Rilke or Frankl. Even if socio-cultural factors are acknowledged, such as losing a job or illness, the therapeutic option is still likely to be medication or cognitive therapy, or a combination of the two, because depression is viewed as a problem that has to be solved. In terms of meaning, then, the consequences of the dominance of the scientific approach to depression, with its scientific rationalist interpretations, is that the freedom Weber saw characterizing

secular modernity also becomes problematic. As Weber recognized, each of us must choose our own values, our own “gods” (Weber 1991: 153), in the modern secular world, yet this choice is both influenced and curtailed by the very rationality that gives us that choice.

This has profound implications for the individual suffering from depression in the modern West. For those depressed individuals who are ‘happy’ with the current framing of depression as an illness, the interpretations and meanings provided, and the treatments offered there is perhaps no need for ‘inconvenient voices’ of any sort. But for those who are not ‘happy’, the existence of ‘inconvenient voices’ (particularly the more ‘radical’ ones) are crucial as a way of accessing other meaning possibilities of depression that are disallowed and closed off by the dominant paradigm of depression.

These ‘inconvenient voices’ are important for those who have found current approaches, interpretations, meanings, and treatments to be seriously wanting, who have become disenchanted with the medical approach to depression, or who may have screamed “‘I will never take another fucking pill in my life’” (Karp 1996: 78). They are also important for those who seek a way of journeying with their depression, rather than against it, believing depression to be, as did one of Karp’s (1996: 104) interviewees, a gift and something to be embraced, and befriended, and learnt from: “‘we’ve got to integrate it into our lives.... If we don’t allow it in, it can be destructive. If we allow it in it is a teacher’”. Likewise, to those who have found standard depression treatments ineffective or have pursued long ‘careers’ experimenting with a variety of treatment options (Karp 1996, 2007) ‘inconvenient voices’ are also valuable in their provision of other possibilities for making sense of depression. If the choices of how to approach depression and what meanings can be assigned are largely ‘fixed’ then choice becomes constrained and restricted.<sup>4</sup> What

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<sup>4</sup> From a different Weberian perspective, while ends-means (*zweckrational*) rationality or action provides causal meaning it is unable to provide meaning of value-means (*wertrational*) rationality. The inherent aim of the former is “mastery of the world in the service of human interests”, however this “gain in control is paid for with a loss of meaning” (McCarthy in Habermas 1984: xvii) previously provided by the latter. In other words, meaning orientations of a causal type (provided by the ‘voices of investigation and explanation’) can jointly tell a person what to do and how to do it and what it means in terms of causality and result; but, they cannot tell why and what it means in terms of values and existential meanings. This is the role of the ‘inconvenient voices’, particularly the more ‘inconvenient’ ones. Even though Weber considered *zweckrational* to be “increasingly salient in modern society” (Brubaker 1984: 52) he also considered that only “by integrating the *wertrational* and *zweckrational* orientations ... can a human live a truly human life *within* the modern rationalized world” (Brubaker 1984: 109).

understandings of depression are provided for the public, and by inference what are not, is the focus of the next chapter.

## 7.6 Conclusion

In no other of the cultural-historical orientations comprising the Quatrefoil Model do ‘inconvenient voices’ raise such compelling and profound questions and issues as in the meaning orientations. The extraordinary force of Western rationalism to restrict meaning within the narrow confines of causality, and the concomitant problems of meaning this creates, are clearly reflected in the depression literature. Indeed, Western rationalism has done something quite ‘specific and peculiar’ to the possibility of meaning: it has circumscribed it, including some meanings and excluding other meanings. Arising from the historical and interpretative orientations (see Chapters Five and Six), the meaning orientations in the contemporary Western framing of depression are characterized almost exclusively by causality, linking them directly to the ‘causality’ end of the motif of suffering concerned with relationship and causality (see Chapter Three: 3.3). Moreover, they are also comprised of the transferred characteristics of the interpretative orientations focussed on defining and solving the problem of depression. It is not surprising, then, that current approaches to depression disallow for an emphasis on relationship of some sort arising from within suffering, as expressed in Western literature from *Job* to the ancient Greek tragic poets to secular atheistic literature, such as Solzhenitsyn’s *One Day in the Life of Ivan Denisovich*, or to religious literature, such as some modern Christian hymns. Rather, they focus on causality of suffering, as did Plato or Job’s ‘friends’.

In this chapter, drawing on Weberian ideas concerning rationality and meaning, Derridean concepts of the two interpretations of interpretation and Levinasian concerns about approaches to the Other, my examination of what meanings are assigned to depression has revealed not only a focus on causal meanings but a closing off of alternative meanings to depression. This creates a problem for the meaning of depression because the possibilities of meaning are severely restricted by this focus on causality. Medical science operates under presuppositions concerned

with “diminishing suffering ... to the greatest possible degree” (Weber 1991: 144). Yet, as Weber (1991:141-144) warned, “this is problematical” because such presuppositions cannot be scientifically proved, only “*interpreted*”, and medicine, as a science, cannot provide meanings that extend beyond its narrow scientific parameters of causality concerned with “the purely practical and technical”.

Specifically, the issues surrounding depression and meaning, and the subsequent complexity and confusion, result from the influence of Western rationalism and its sole focus on scientific rationality. Yet, it is the delimiting of meaning, fuelled by Western rationalism, that is of central significance in understanding *why* some meanings are privileged, some meanings are of marginal interest, and others are precluded, consigned to a liminal existence at the edges. The construction of meaning in secular modernity needs to cope with complexity and plurality, be reasonable, and not closed (Berger 1992). It is the ‘inconvenient voices’ that both supply the means of understanding the problems of closed systems of meaning and the wherewithal of embracing inclusivity of meaning.

The vast majority of medical literature, in particular, clearly demonstrates acceptance of the dominant medical paradigm of depression and the interpretations and meanings assigned, but there are growing voices of concern. Such concern, and the search for alternative approaches, is also evident in the sociological literature. Examination of the growing number of ‘inconvenient voices’ in the area of depression reveals a concern that the dominant medical position is in need of a ‘re-thinking’. These ‘inconvenient voices’ point to gaps and difficulties in the medical paradigm, and reveal the problem Weber identified when science is used beyond its parameters. It is not that the majority of approaches in either medicine or sociology are erroneous or incomplete or that meanings are inadequate, but that science has been applied beyond its narrow parameters. This overextension beyond the borders of scientific rationality create, I suggest, what often appear to be flaws or problems but are actually the way by which the issues surrounding the meanings of depression can be investigated. Wootton (2007: 283) argues that historically medicine only became effective when “doctors began to count and then to compare”, but that this process of change was slow. While this counting and comparing has revolutionized medicine, and continues to do so as science and technology advance new ways of

investigating and explaining, I suggest that the next phase in medicine's evolution could be to continue this counting and comparing while *also* embracing an openness to 'other' in respectful dialogue. These matters are the focus of Chapter Nine.

Depression is many journeys with many meanings, not only the ones provided by medicine and sociology, valuable as these are. Levinas asks, what would it mean if we responded to the Other with respect instead of violence (Davis 1996: 144)? What would it mean, then, if instead of cutting claws and wings and beak we responded to the 'falcon' with respect instead of violently trying to turn it into a 'pigeon'? Unfortunately, overall, the contemporary framing of depression is constitutionally unable to furnish or facilitate understandings that perhaps a 'falcon' is not a 'pigeon', or not *always* a 'pigeon' or might actually *choose* to remain a 'falcon', and thus depression is termed illness and abnormality that must be controlled and cured so health and normality can be reinstated.

So, the answer to the question of what would it mean if we responded to depression, as a face of the Other, with, not violence, but respect is to be found in the 'inconvenient voices'. They reflect both the problems inherent in the meanings assigned by Western modernity to depression and offer ways to 'other' meanings that are complex and inclusive. It is the combination of 'voices of investigation and explanation' and 'inconvenient voices' that together are able to accommodate the need to treat depression (Ebmeier *et al.* 2006) and the need to move beyond depression (Dowrick 2004): in short, the right to be fully human, that includes the right to be depressed. Towards the end of Huxley's *Brave New World*, echoing Plato's assertion that if "part of our humanness is our susceptibility to certain sorts of pain, then the task of curing pain may involve putting an end to humanness" (Nussbaum 1986: 120), the Controller explains to the Savage that "[u]niversal happiness ... has got to be paid for somehow and the guarantee of comfort requires losing other experiences that are part of being human" (Nettle 2005: 172). To this the Savage replies:

But the tears are necessary.... I don't want comfort. I want God, I want poetry, I want real danger, I want freedom, I want goodness, I want sin.... I'm claiming the right to be unhappy. (Huxley 1955: 185, 187)

# Chapter Eight

## Public Orientations: Ascent

**The world is in desperate need of ... maladjustment.**

(Martin Luther King, Jr.)<sup>1</sup>

**The trouble with life isn't that there is no answer, it's that there are so many answers.... What we call 'answers' are ... attitudes taken by different temperaments toward certain characteristic problems – even the interrogation may be an 'answer'.**

(Ruth Benedict)<sup>2</sup>

**Procrustes ... had an iron bedstead, on which he used to tie all travellers who fell into his hands. If they were shorter than the bed, he stretched their limbs to make them fit; if they were longer than the bed, he lopped off a portion.**

(Greek Myth recounted by Thomas Bulfinch)<sup>3</sup>

### 8.1 Introduction

The focus in this chapter is on the orientations to depression that are provided to the general public. Primarily through an examination of *beyondblue*, a leading Australian depression website, I explore what the material presented to the public communicates to them about depression. In what I have termed 'public orientations' (see Chapter Four: 4.2.4), I am interested in determining the dominant perspectives on depression that are promulgated and the perspectives that are excluded. In addition to examining the content of such material provided to the public I am also curious to compare this content against my findings in the preceding chapters to determine whether historical, interpretative, and meaning orientations evident in the medical and

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<sup>1</sup> Wallis 2008: 53

<sup>2</sup> Mead 1966: 126

<sup>3</sup> Bulfinch 1962: 189



sociological literature are replicated or whether the foci and emphases have shifted. My research indicates that the dominant feature characterizing the public orientations to depression is a focus on specifically defined routes to understanding and dealing with depression. These routes manifest as journeys in one direction only, which strongly positions the public orientations to depression at the ‘ascent’ polarity of the ‘descent / ascent’ motif of suffering discussed in Chapter Three (3.5).

Given the pervasive influence of a total world-view perspective in the historical orientations, the emphasis on defining and solving the problem of depression evident in the interpretative orientations, and the focus on causal meaning in the meaning orientations, it is perhaps inevitable that the public orientations are strongly characterized by an attitude towards depression of ascent away from depression. Such a focus on ascent reflects the emphases on certainty, resistance, and causality discussed in the previous chapters, and is reflective of a constituent part of long-standing Western attitudes to suffering. In the contemporary West can be discerned a particular emphasis on these characteristics, and aversion to their polar opposites of chaos, acceptance, relationship, and descent. Only the presence of ‘inconvenient voices’, particularly evident in the meaning orientations, stand as reminders of the existence of other approaches to suffering that also characterize aspects of this Western approach to suffering. However, I argue in this chapter that such ‘inconvenient voices’, while evident in some material in the public domain, are absent from the dominant material that constitutes the public orientations, such is the narrow focus on ascent and the outright rejection of descent into suffering.

The public orientations to depression, then, constitute a journey of ascent away from depression with a clearly defined route and destination. In this chapter, once again drawing on Weber’s concepts of a total world-view and the role of the elite, Derrida’s concept of the Rousseauistic interpretation, and Levinas’s concepts of Same and Other, I explore the public orientations to depression through an examination of *beyondblue* and other public domain depression resources. Discussions proceed around the perceived need to educate the public and the implementation of measures to address this need, the discourse on depression made available to the public, how these contrast with findings in the previous orientations, and what the implications are for individuals dealing with depression.

## 8.2 Background

The large burden of depression worldwide (Olfson *et al.* 2002, Moussavi *et al.* 2007), lost productive work due to depression (Stewart *et al.* 2003), and the effect of depression on individuals, families and communities (Highet *et al.* 2004) reinforces medical opinion concerning the need for educating the public about depression as a treatable illness in order to reduce its prevalence. It is estimated that although “more than 800,000 Australians experience depression each year, less than 40% of affected individuals present for care and fewer than one in six receive an evidence-based treatment” (Hickie 2002b: S61). There is “substantial potential to improve the management of depression in primary care”, and it is argued that the need for considerable public resources, improved organization and care provision will need to be addressed before better treatment outcomes for depression can be attained (Gilbody *et al.* 2003: 3145). In addition, in 2002, Highet and colleagues (S68) reported that “mental health campaigns will need to be of considerable intensity and duration if they are to affect public awareness and understanding... [and] still have a long way to go to achieve meaningful changes”.

Research indicates a conflict between the public’s reliance on medicine and its disillusion with medicine (Lupton 1994). In addition, it has been found that accessing medical help for any mental illness and subsequent treatment compliance is determined not by medical beliefs but by lay beliefs (Haslam 2007, Jorm & Kelly 2007). From the medical point of view, this problematic situation is further compounded by a negative public attitude towards drug treatments for depression and a preference not only for self-help strategies but to also “consult family and friends, and other community-based supports, rather than general healthcare professionals or mental health experts” (Highet *et al.* 2002: S63). Opinions that “lay people are not experts.... and can often be plain wrong about the causes, course and management of common forms of disease and illness” (Prior 2003: 45) underlie increasing emphasis on the need for public education. The existence of both negative opinions of drugs and poor treatment compliance by the public (Mitchell 2006) and their ambivalence toward antidepressants and their doubts about the medical model of depression (Barr & Rose 2008) are viewed by the medical profession as serious

impediments to the successful management and treatment of depression at both the individual and national levels. Although there has been an increase in the prescribing rates of antidepressant treatments for depression and an increase in public depression literacy, there remains a “lack of significant change in psychiatrists and / or psychologists being perceived as therapists of choice” (Goldney *et al.* 2005: 134). Such attitudes reinforce the medical emphasis on the continued need for education of the public about the expertise of health professionals in the treatment of depression.

Public awareness and education campaigns are premised on the hope that increased depression literacy (as defined by medicine) will encourage patients to seek expert professional help and will increase the acceptance of antidepressants as effective treatments. In providing information about depression symptoms to the general public, it is also considered that this “might facilitate correct diagnosis, as patients who self-label as depressed are more likely to receive an appropriate diagnosis” (Griffiths & Christensen 2002: S100). Community-based education programmes, with local community involvement, have been found to be particularly effective in disseminating information about depression (Cole 2007). The National Index for Depression in Australia has been devised as “a valid indicator of depression and level of depressive symptoms” within the Australian community, and is so structured that it can be interpreted by the general public (Mackinnon *et al.* 2004: S52). It is intended that the data from this Index will be released and move into the public arena, in much the same way as suicide rates and road fatalities have become a part of national public awareness (Hickie 2004a). In addition, there is growing evidence that favours screening for depression in the general population using appropriate screening tools at the primary health care level (Hickie *et al.* 2002, Peveler *et al.* 2002, Henkel *et al.* 2003).

Considerable efforts have been made in Australia to improve the depression literacy of the general public (Hickie 2004a, Goldney *et al.* 2005, Jorm *et al.* 2006b). There is evidence that between 1995 and 2003-2004 the beliefs of the public about mental illness and treatment had changed to become more in line with those of mental health professionals (Jorm *et al.* 2006a). The *beyondblue* initiative in Australia is one of a number of campaigns across the world designed to improve depression literacy in the general public (Parslow & Jorm 2002). The aim of *beyondblue*, the national

Australian response to depression, “is to promote effective population health-based strategies” (Hickie 2002b: S61). Likewise, the *Better Outcomes in Mental Health Care (BOiMHC)* initiative (Fletcher *et al.* 2008) has expanded the national capacity of general practitioners to respond to the needs of the mentally ill, including depressed patients (Hickie *et al.* 2004), and the *KBA (Keeping the blues away)* programme was found to be promising for some depressed people (Howell *et al.* 2008). The *Black Dog Institute*, attached to the Prince of Wales Hospital and the University of New South Wales, is another example of the efforts to both diagnose and treat depression more effectively, educate the public about depression, and continue research into depressive illness and other mood disorders.

### **8.2.1 *beyondblue***

The not-for-profit organization *beyondblue* is “the national depression initiative” (*beyondblue*: Homepage) of Commonwealth, State and Territory governments and works closely with those suffering from depression, schools, community groups, universities, the media, work places, and health care providers (‘About Us’: 1). “Many Australians have limited knowledge and inaccurate beliefs about depression” and *beyondblue* specifically targets these issues in its primary aim of increasing public awareness about depression (Parslow & Jorm 2002) and reducing the stigma experienced by many people with depression (McNair *et al.* 2002). It also works to address issues in the areas of anxiety and substance abuse, which tend to be closely related to depressive illness. The mission statements and priorities of *beyondblue* (‘About Us’: 1-2) are highly focused on improving the national response to depression in a collaborative and co-ordinated way: *beyondblue* respects and recognizes special needs and diversity in the population, assists those suffering from depression and their families and promotes their needs and experiences to policy makers and health professionals, is sustainable and evidence-based, supports and trains health care workers, initiates and supports research into depression, and actively develops effective intervention and prevention programmes.

The *beyondblue* organization, established in 2000 by the Victorian and Commonwealth governments, achieved early success in its stated objectives (‘About

Us: Our History': 1, Hickie 2004). Such achievements position this “coordinated population health response to the burden of depression” ahead of most other developed countries (Hickie 2004: S5). In their review of Australian depression websites, Griffiths and Christensen (2002) rated *beyondblue* as one of only four recommended sites having the highest quality of content. This success has continued, with research in 2005 showing *beyondblue* had a positive effect on the public in raising depression recognition and on some beliefs about depression treatment (Jorm *et al.* 2005) and in 2008 the *beyondblue* website was ranked, based on usage, as the top Australian health and medical organization website (*beyondblue*: Homepage).

The high public profile of *beyondblue* has also been sustained and extended through widespread advertising. For example, letter-box drops to “every household in your State” of “a *beyondblue* depression checklist and fridge magnet” (from the accompanying flyer distributed in Tasmania in November 2008) are designed to further increase public knowledge about depression. Through the recruitment of public figures from politics, sports, and the arts as ambassadors for *beyondblue* (such as Jeff Kennett, Nathan Thompson, Gary McDonald) the presence of *beyondblue* as the national voice on depression is further strengthened. The recent launch in May, 2009 of the *youthbeyondblue* website (separate but directly linked to the *beyondblue* website), specifically designed for young people, is the latest example of this organization’s expansion and its continued commitment to reducing Australia’s burden of depression.

The *beyondblue* website is designed primarily for public use and is user-friendly. It is very easy to navigate in the search for information, advice, or contact details. The website does, however, also contain material for health care providers. A combination of broad education about depression and assistance to those suffering from depression and to their families is the focus of much of the material on the *beyondblue* website. A wide range of resources, including fact sheets, printed resources and merchandise available for ordering or downloading, brochures, suggested reading lists, and contact details is presented on well-laid out web pages. The information about depression is simply and clearly presented. During my examination of this website I found the downloading and printing of material entirely problem-free. In particular, because the information is presented in menus and small

sub-sections it means that the user can select to print only certain material, thereby avoiding the annoying situation of printing off thirty pages for the two pages required. While no expert on website design I judge that a great deal of time and research has gone into the design of the *beyondblue* website and into the organization and writing of its material. Indeed, for someone with embarrassingly limited internet and computer capabilities I found the website extraordinarily simple and easy to use and impossible to get lost in. Such ease of use has almost certainly contributed to its success in the public domain.

Throughout the *beyondblue* website there is an overall emphasis on depression as a serious and common illness that needs effective medical treatment. This approach to depression is also evident in other material produced for the public domain. Books such as Aisbett's *Taming the Black Dog* (2000), Rowe's *Depression: The Way out of Your Prison* (2003), Matthew and Ainsley Johnston's *Living With a Black Dog* (2008), and Parker's *Dealing With Depression: A Commonsense Guide to Mood Disorders* (2002) and other depression websites such as the *Black Dog Institute* and *BluePages* all portray depression as an illness to be overcome. That depression could be considered other than as illness to be rectified is anathema to the ethos operating in *beyondblue* and most material about depression available for public consumption. The public orientations to depression are prescriptive in their defining of depression as an illness requiring treatment according to evidence-based medicine. This reflects a total world-view or Rousseauistic Interpretation in which there is but one perspective and which proclaims the expertise of the medical elite over the laity in explaining and solving the problem of depression.

### **8.3 The Journey Defined: The Destination Selected**

The information about depression on the *beyondblue* website constitutes what could be described as a map showing how to ascend out of the abyss of depression. This map defines a journey towards the selected destination of recovery from depression. There are multiple signposts indicating directions to take, suggesting requirements for the journey, and advising how to cope with the difficult terrain. The emphasis is

on assisting those with depression to recover and to prevent return episodes. There is also advice to help people identify those who have depression and therefore who need assistance to journey out of their depressive illness. The *beyondblue* website focuses on reassuring people that depression is common but that recovery is possible with treatment from the medical profession and help from family and friends.

Material on the *beyondblue* website can be viewed from a variety of access points. There are over thirty fact sheets detailing information ranging from: causes of depression (Fact Sheet 3), to the combining of psychological and medication treatments (Fact Sheet 5), to the importance of reducing stress (Fact Sheet 6) and improving sleep (Fact Sheet 7), to the value of exercise (Fact Sheet 8), to the types of antidepressants (Fact Sheet 11), to alternative treatments (Fact Sheet 14), to recovery from depression (Fact Sheet 15), and to Medicare information (Fact Sheet 24). There are also information sheets providing advice and information on such things as informing your employer about your depression, understanding depression, checklists for depression, and how to help those with depression. In the 'Frequently Asked Questions' section, the same type of information is presented in a different format. Brochures are also available, for downloading and printing, about depression generally and about organizing public forums on depression in one's local community, which again present the same type of information in different formats. There are also numerous resources available for ordering from the *beyondblue* organization. While this material is repetitive, it has been well designed and organized to educate the public about depression in presentations that are not tedious. The material restates in different ways the depression message that *beyondblue* promotes: depression is very common, it is not a personal failure, it is an illness, it needs medical treatment, and it can be effectively treated by health professionals.

The depression information on the *beyondblue* website is reflective of the dominant medical approach to depression that views depression as a serious and common illness that can be effectively treated and prevented. For example, the causes of depression are presented as arising from a combination of recent events and stresses, medical illness and treatments, and individual factors that include personality-type, genetic and chemical factors, and previous negative experiences (Fact Sheet 3). Combination treatment for depression is presented as necessary to effectively treat

depression (Fact Sheet 5). While selection of treatment must suit the individual (the type of drug or counselling) both medication and counselling are advised in order to “relieve physical symptoms and correct negative thoughts” (Fact Sheet 5: 1). Alternative therapies are also addressed, and are divided into three sections of ‘good evidence’, ‘some evidence’, and ‘poor evidence’. St John’s Wort (*hypericum*) and physical exercise are included in the ‘good evidence’ section, acupuncture and massage are included in the ‘some evidence’ section, and chocolate and prayer are listed in the ‘poor evidence’ section.

The *beyondblue* website specifically gives advice on how to reduce stress (Fact Sheet 6), sleep well (Fact Sheet 7), keep active (Fact Sheet 8) and change thinking (Fact Sheet 10) as important ways to prevent depression and augment depression treatments. There are a number of Fact Sheets devoted to helping men understand depression (Fact Sheet 12), on the elderly and depression (Fact Sheets 17, 20, 25), on postnatal depression (Fact Sheet 22), and on other illnesses and depression (Fact Sheet 23), such as heart disease (Fact Sheet 18), arthritis (Fact Sheet 27), and diabetes (Fact Sheet 19). Other related topics such as anxiety (Fact Sheet 21) and bipolar disorder (Fact Sheet 16) are also covered in detail with advice on symptoms, treatment, and management.

Detailed depression checklists and symptoms ‘test sheets’ are amply provided in a number of different locations on the website to help identify the symptoms of depression and indicate whether a person is suffering from depression. Emphasis throughout is on accessing health care professionals to receive treatment as soon as possible. Explanations are given of the different kinds of health professionals, such as doctors, psychiatrists, psychologists and other health care workers. Depressed people and their families are also advised of the dangers of self-medicating with alcohol and other drugs and that without correct medical treatment the symptoms of depression will worsen. Other fact sheets provide advice on the recovery process (Fact Sheet 15), and information about how to assist and care for someone with depression (Fact Sheets 1 and 2).

There are also a number of fact sheets devoted to practical matters such as the types of rebates available under Medicare and work place issues. In Fact Sheet 24, details



are provided about the types of consultations, the lengths of consultations, the different professionals carrying out these consultations, the rebates available under Medicare (including the dollar amounts for scheduled fees and rebates), how to access these various sorts of treatment, and contacts for additional information. In one of the information sheets details are provided about obligations to inform or not inform employers about depressive illness, legal protection, tips on discussing depression with an employer, and contact details. Addressing such issues reflects a concern with the reality of depression in a person's everyday life of money and work. This attention to practical details provides vital information not necessarily available from health professionals but crucial to assist individuals in seeking treatment and negotiating how to handle depression in their lives. The range of topics covered on the *beyondblue* website are inclusive of many aspects of depression, and includes information about how depression relates to life, family, and work that are likely to be of interest to members of the public.

The journey away from depression to the destination of recovery characterizes the detailed map provided by *beyondblue*. All advice is designed to assist a depressed person, or family or friends of a depressed person, to understand what depression is and what is involved in recovery. Health professionals are the experts to whom the public must turn to receive advice and treatment. The public orientations to depression evident in Australia's national initiative to reduce the burden of depression are reflective of many of the characteristics of the historical, interpretative, and meaning orientations to depression discussed in the preceding three chapters.

The historical orientations (Chapter Five) are evident in the focus in *beyondblue* on the presence of a total world-view, the restricted focus on scientific evidence-based approaches to depression, and the emphasis on the authority of the elite over the laity in the advice to seek professional help. In the emphasis in *beyondblue* on defining the problem of depression through checklists and descriptions of depression and through solving depression via wide-ranging advice on treatment can be seen the interpretative orientations (Chapter Six). Finally, the meaning orientations (Chapter Seven) are reflected in *beyondblue*'s narrow focus on matters of causality and treatment. What is particularly noteworthy, however, is the complete absence in the

public orientations to depression of ‘inconvenient voices’ that are present in the previously discussed orientations to depression. The information about depression on the *beyondblue* website is presented as authoritative and certain. Indeed, so authoritative and certain that all the disagreements and differences of opinions, let alone the ‘inconvenient voices’, are completely absent. While providing an arguably comprehensive view of depression, *beyondblue*, nevertheless, actually provides a simplistic and idealistic view of depression. In a sense, the *beyondblue* website provides an easy-to-read map detailing how to traverse the terrain of depression and how to reach the destination of recovery. However, this map is a simplified version designed for the public that belies the reality of topographical complexity and the disagreements over how to ‘draw’ and ‘read’ the map of depression.

## 8.4 Appraisal of the Journey and Destination

Material provided on the *beyondblue* website represents a well-devised and successful presentation of one particular perspective on depression. However, when compared to the material in the medical and sociological literature there are both contrasts and similarities to be found. The professional literature in both medicine and sociology is replete with contestation and difference of opinion. This reflects science as operating on the principle of doubt, not certainty, even though certainty is continually sought after. The historical, interpretative, and meaning orientations to depression have coalesced in the public orientations into a seemingly precise and clear understanding of depression and its treatments. Cole (2007), commenting about a Victorian depression community programme, is particularly cognizant and honest when he admits that as “often happens, what is useful for education does not necessarily correlate with the medical condition or treatment of the illness”.

The public face of the contemporary Western framing of depression is the epitome of what is sought after in the historical, interpretative, and meaning orientations: the certainty afforded by a functioning total world-view, without the destabilizing effects of plurality, and with a powerful elite; resistance to the problem of depression through clear and concise definition and solution; and clearly delineated causal

understandings of depression through investigation and explanation. In this version, there is no divisiveness, no difference of opinion, and certainly no ‘inconvenient voices’. This constitutes the ideal total world-view in operation, something no longer possible in the contemporary West (see Chapter Five and 8.5). However, this is a simplified account, a streamlined rendition of the contested and complex subject of depression. There are both considerable advantages and considerable disadvantages to be found in these public orientations to depression.

### 8.4.1 Contrasts and Similarities

The *beyondblue* approach to depression is highly representative of the medical approach to depression, but diverges in a particularly pertinent way. While the medical and sociological literature is characterized throughout by disagreement and difference of opinion, this has not transferred into this material produced for the public. The emphasis on certainty, resistance and causality has coalesced in the public orientations into ascent. This, in many ways, constitutes the contemporary Western framing of depression: ascent from depressive illness into emotional, mental and physical health; ascent from abnormality to normality; ascent from problem to solution; ascent from the negative to the positive; ascent from depression to happiness.

Drawing attention to a few examples of the gap between what is conveyed about depression in the historical, interpretative, and meaning orientations and what is conveyed in the public orientations will illustrate the idealistic nature evident in the public orientations to depression to be found on the *beyondblue* website. This gap is not indicative, however, that the perspective on depression promulgated by *beyondblue* is faulty, erroneous, or inadequate; rather, it is indicative of a successful presentation of *one* perspective that has also been simplified for public consumption.

The causes of depression listed on the *beyondblue* website are holistic in their inclusion of recent events (such as family conflict or losses), other medical illness or treatment (such as heart attack or medications), and personal factors (such as anxiety, traumatic experiences in the past, family disposition, and personality type). Risk

factors for depression are extremely inclusive of demographic variables such as sexual orientation, ethnicity, living in remote or rural areas, and substance abuse ('Depression: What Puts a Person at Risk': 1). This holistic and inclusive approach to considering the causes and contributing factors in depression may reflect an attempt by *beyondblue* to position depression as both a social as well as an individual biological illness. Such an attitude is clearly reflected in their broad combination treatment guidelines. The *beyondblue* perspective on the causes of depression reflects points of view about depression in much of the sociological and medical literature (Insel & Charney 2003, France *et al.* 2004, Ebmeier *et al.* 2006, Horwitz & Wakefield 2007). However, the considerable emphasis on chemical and genetic causes of depression in the medical literature (Barondes 2003, Ebmeier *et al.* 2006, Meyer *et al.* 2006, Bennett 2007) is absent. It is interesting that *beyondblue*, while inclusive of social variables as causal factors in depression, do not include them in their checklists of diagnostic symptoms. This directly reflects the approaches to depression evident in *DSM-IV*, in which variables in Axis IV (such as stress, poverty, unemployment) are acknowledged by *DSM* but discounted in subsequent diagnostic criteria (Horwitz & Wakefield 2007).

Both exercise and St John's Wort (hypericum) are detailed in *beyondblue* as having good evidence as alternative treatments for depression. However, in the case of exercise, while some opinion (Jorm *et al.* 2002) considers exercise as belonging to the category of complementary and self-help treatments for depression having the best evidence for efficacy, doubt has also been cast on research results advocating the efficacy of exercise for the treatment of depression due to poor trial design (Lawlor & Hopker 2001). Other research has also found that while exercise was positively related to reduced symptoms of depression no causal effect was determined (De Moor *et al.* 2008). Similarly, while hypericum is rated highly as an alternative treatment for depression by some researchers (Philipp *et al.* 1999, Szegedi *et al.* 2005) it is dismissed by other researchers who found no evidence of efficacy (Shelton *et al.* 2001, Hypericum Depression Trial Study Group 2002, Kupfer & Frank 2002). In presenting only some of the available information about such alternative treatment options for depression *beyondblue* is effectively limiting the knowledge presented to the public to partial perspectives that are only representative of some opinions.

Also in the area of depression treatment, *beyondblue* details antidepressants as effective for treating depression as though this was an undisputed fact. While this position is substantiated by much research (Insel & Charney 2003, Mann 2005, Ebmeier *et al.* 2006), other research and opinion considers antidepressants no more efficacious than the placebo (Dewhurst 2004, Healy 2007, Lenzer & Brownlee 2008, Mayor 2008). Moreover, *beyondblue* does not reveal that research differs as to the efficacy of antidepressants (Insel & Charney 2003, Moncrieff & Kirsch 2005, Ebmeier *et al.* 2006) and that some research indicates that efficacy is not much above fifty percent (Keller *et al.* 2000, Mann 2005, Rubinow 2006). In addition, the problematic area of drug trials and the restricted and biased publication of results (Healy 1997, Dewhurst 2004, Geddes & Cipriani 2004, Ramchandani 2004, Healy 2007, Turner *et al.* 2008) and the disagreements, problems, and concerns about EBM (Sackett *et al.* 1996, White & Willis 2002, Goldenberg 2006, Kendrick *et al.* 2008) are not mentioned on the *beyondblue* website in terms of their potential impact on advice about antidepressant treatments for depression. A combination of counselling and medication is presented on the *beyondblue* website as necessary to effectively treat depression. However, this position belies the contested opinion about the differences between the efficacy of counselling versus medication and even about the efficacy of combined treatments (Vos *et al.* 2004, Beck 2005, DeRubeis *et al.* 2005, Rey & Dudley 2005, Ebmeier *et al.* 2006, Hollon 2006).

Concern over the medicalization of human sadness as depression that is evident in the professional medical and sociological literature (Karp 1996, 2007, Dowrick 2004, Shaw & Woodward 2004b, Blazer 2005, Horwitz & Wakefield 2005, 2007) is not evident in the material on the *beyondblue* website. Indeed, the increasing interest to be found in both the medical and sociological literature concerning the demarcation of normal sadness from depressive illness (Karp 1996, 2007, Kleinman 2004, Parker 2007, 2008a, Horwitz & Wakefield 2007) is quite absent from information about depression presented on the *beyondblue* website. The simple checklists to determine if depression is present, as opposed to normal sadness, are provided by *beyondblue* as though they were undisputed diagnostic criteria. The number of and type of symptoms (such as trouble sleeping, feeling sad or miserable most of the time, having poor concentration and energy, and so on) and the length of time during which these symptoms have occurred (must be more than two weeks) are

clearly stipulated. Yet, the recognized diagnostic problems of defining depression and differentiating it from normal sadness that are evident in the medical and sociological literature are not referred to in *beyondblue*. Indeed, reference to criticisms of, and disagreements about, diagnostic guidelines (Ellis *et al.* 2004a, Parker 2004a, Horwitz & Wakefield 2007, Parker 2007, 2008a, Joyce 2008) is absent from *beyondblue* material about diagnosis of depression, even though their diagnostic criteria are based on such guidelines.

The outright rejection of depression as anything but illness evident throughout material on the *beyondblue* website is also interesting in terms of concerns in both medicine and sociology that the designation of unhappiness as depression potentially excludes unhappiness from the fullness of what it means to be human. The rejection of irrationality and the resistance to emotions Weber saw characterizing the Protestant ethic (Brubaker 1984, Weber 2001) has transferred in the contemporary secular West into an abhorrence of negative emotions (Morgan 2002, Williams 2004b). Such abhorrence can be seen in the way that, for example, *beyondblue* provides information and advice about controlling, subduing, and treating depression with the end-point of recovery from depression as the goal. From such a perspective negative emotions such as depression, and also anxiety, must be got rid of or at least controlled. Concern over attitudes of resistance to certain emotions and emotional behaviour (such as depression, anxiety, shyness) that result in their medicalization as illness has resulted in research examining such attitudes, and their implications, and promoting attitudes of inclusiveness (for example, Dowrick 2004, S. Scott 2006). These ideas and concerns are completely absent from the *beyondblue* website.

Information is provided by *beyondblue* (Fact Sheet 11) to counter the “great deal of misinformation about antidepressant medication”. While acknowledging that antidepressants can have side effects, *beyondblue* advises that they are “safe, effective and not addictive” (Fact Sheet 5). This is perhaps a partial truth, but there is considerable concern and disagreement, for example, about antidepressants and suicide (Ankarberg 2003, Hall *et al.* 2003, Moncrieff 2003, Fergusson *et al.* 2005, Goldney 2006, Hall & Lucke 2006, Friedman & Leon 2007). There is also some medical research acknowledging that antidepressant medications, while not addictive, do cause withdrawal and discontinuation symptoms (Ebmeier *et al.* 2006).

The *beyondblue* website also advises that antidepressant medication “will not change ... [an individual’s] personality or make them feel happy all the time”. However, there is research indicating that antidepressants may alter the personality or a person’s sense of who they are (Karp 1996, 2007, Rose & Barr 2008). In addition, authenticity, and the relationship between self-hood, identity and drugs, is of considerable importance to those taking medication for their depression because many “felt that medication made them different” (Karp 2007: 97).

Considerable emphasis in the material on the *beyondblue* website is placed on the individual to monitor their health, in terms of the checklists provided, and also that of friends and family members, to determine if someone is likely to be suffering from depression. Self-monitoring followed by accessing a doctor or health care worker as soon as possible if depression is suspected is stressed throughout the website as essential and necessary behaviour for the individual in order to reduce depression in the community and to improve people’s lives. This approach constitutes a massive public campaign advocating the monitoring of self, family members, and friends. It is promoted without any apparent awareness of concerns over issues of risk and surveillance, particularly evident in sociological research (Lupton 1994, 1995, Petersen & Lupton 1996, Williams & Bendelow 1998, Lauritzen & Sachs 2001, Shaw & Woodward 2004a), or over the transformation of the public into the “worried well” (Williams 2001: 143, Bell 2005).

Other issues, such as how depression is framed impacting on diagnosis and treatment criteria (Aronowitz 2008a) and the impact of the growth of the profession of psychiatry on the diagnostic category of depressive illness (Moncrieff & Crawford 2001, McPherson & Armstrong 2006), are also absent from material presented on the *beyondblue* website. While references are often given and reading lists are provided, it would take a substantial amount of self-directed research and extensive reading of professional literature for an individual to access the existence of the broader pool of material about depression that is available and to understand it. Moreover, accessing such references may incur considerable financial costs. In so tightly defining the journey of depression and selecting the destination, members of the public are manoeuvred in one direction. While such a direction and destination may have advantages, it also has disadvantages. As a result, the public orientations to

depression as evident in *beyondblue*, with their focus on a specific journey with a specific destination, are, I suggest, restricted and exclusive because they transmit only a part of the historical, interpretative, and meaning orientations to depression that are available in the contemporary framing of depression in the West.

### **8.4.2 Advantages and Disadvantages**

The orientations to depression presented for public consumption by *beyondblue* represent an idealized form of the historical, interpretative, and meaning orientations: that is, they represent a form of the contemporary Western framing of depression that is simple and certain, with all the contestation removed. On the one hand, this is a reasonable and understandable approach. To present a summarized form of all the differences of opinion and lack of clarity concerning depression available from the medical literature, in particular, would likely result in overwhelming confusion for the public and increased disinclination to access medical help. The stated objective of educating the public and improving diagnosis and treatment would, then, not be achieved. Indeed, concerns in the medical profession over misinformation and misunderstandings about depression in the general public and their reluctance to consult medical practitioners for assistance would probably be exacerbated.

On the other hand, however, the information provided, while not entirely constituting misinformation, does constitute a form of propaganda in that it presents only one approach to depression as though this were the only one and the correct one. This benign propaganda serves the mission statements of *beyondblue* admirably, but what of the rights of the individual to freely choose? A member of the public accessing this website, without the benefit of a wider perspective on depression from other sources, will form the opinion that depression is understood, that it is an illness, and that it requires medical treatment of some sort. Only those individuals who actively seek alternative ways of considering depression will ever come to the realization that the contemporary Western framing of depression so precisely and effectively packaged for public consumption by this organization constitutes a representation of but one perspective, and not a homogenous perspective at that. Unfortunately, then, the freedom of choice for the individual that Weber saw resulting from the



domination of the Western rationalist emphasis on formal rationality over ethical substantive rationality has, in reality, not materialized. There may be freedom to choose, but the choice is delimited to one possibility only. This dilemma is a problem for all initiatives designed to inform the public about any issue. The message must be simplified and authoritative. To have also included the many points of disagreement and divergent opinion and the ‘inconvenient voices’ on the web pages and in the published resources of *beyondblue* would be decidedly counterproductive. However, such an approach inadvertently constructs ““blueprints of what people ought to be feeling, ought to be like” and medicine “can too easily set about trying to manipulate or even force people into these blueprints”” (Williams 2000b: 571, quoting Craib).

The education of the public about depression delivers material that has been screened of difference and divisiveness. Information about depression provided by *beyondblue*, ranging from topics such as symptoms to be aware of, diagnosis, treatment, antidepressants, Medicare entitlements, and the value of exercise, fit seamlessly together and constitute a well-drawn map of ascent. This attractive and simple map gives detailed and explicit directions about how to ascend from depression. In the public orientations to depression, depression is an illness that is understood and must be treated by medical professionals, and the public need to be educated to assist those who are depressed, and to guide others in helping depressed individuals. However, such a simple map does not necessarily translate into reality for the majority of those experiencing depression. Indeed, Karp (2007: 8) explains that for himself and for most of his interviewees the experience of living with depression “is an uncertain journey”:

It is easy to get horribly lost. There are no maps. You’re driving on dimly lit and poorly marked roads that require constant guesses about which turns to take. Unsettling detours are the norm. The trip is exhausting and you never quite know how far you have travelled. You hope to get to a healthy place, but you’re not sure where it is, whether you’ll ever arrive, or even that the destination exists for you.

Such a description stands in striking contrast to the clear and simple map and single destination proffered by the public orientations to depression found in *beyondblue*. The vast chasm between these two positions speaks to the divide between theory and

reality. It also points to the stark disparity between the medical picture of depression and its treatment, as presented by *beyondblue*, and both the complexity and disagreement existing in the academic literature on depression and the painful and ambiguous experience of many of those traversing the difficult terrain of depression.

The public orientations to depression represent a carefully designed version of the historical, interpretative, and meaning orientations to depression: the public face of the contemporary Western framing of depression that is simple, clear, and easy to understand. A positive result of this is that people are increasingly likely to interpret their emotional problems as illness and to access medical help (Griffiths & Christensen 2002, Horwitz & Wakefield 2005). A negative result is that people are increasingly persuaded that normality equals happiness and are consequently becoming resistant to feeling unhappy (Williams 2000b, Kangas 2004, Shaw & Woodward 2004), a situation paradoxically caused by the medical efforts to cure depression in the first place.

While presenting only a narrow perspective to the public about depression, the information is designed to assist struggling individuals and their families and friends cope with depression. Nevertheless, *beyondblue* limits the public orientations to simple journeys of ascent towards a destination of recovery. Such an idealized and simplistic map of depression, although succeeding in being reassuring and authoritative, does not constitute the entirety of the subject, and nor does it allow for those ‘inconvenient voices’ that totally upturn such a perspective or the experiences of many who have found no such simple map or clear destination. I hold concerns with regard to the restricted nature of information about depression presented to the public and about the lack of ‘inconvenient voices’. Ignoring the many ‘inconvenient voices’ reinforces and further directs the journey to one of overall ascent. The paternalistic focussing of the public orientations to depression on diagnosis, treatment, and recovery according to a simplified and selective medical version converge into a coherent narrative of ascent from depression. Such a focus, while reflective of wider Western attitudes towards suffering and failure, happiness and success, prohibits any journeys other than those prescribed and any other destinations other than those selected. Presenting one opinion as definitive fact is characteristic of a total world-view, the centred Rousseauistic Interpretation, and the Western impulse

to change Other into Same in order to control. Without doubt, such public orientations to depression ensure benefits not possible had the contestation and divergent opinion evident in the professional literature and the existence of ‘inconvenient voices’ been included.

### **8.4.3 The Common Storyline: A Journey of Ascent**

The position taken by *beyondblue* towards depression is characteristic of most approaches to depression evident in material produced for the public domain. There is an extraordinary amount of material published in the self-help area explaining how to overcome, in one way or another, depression and other mood disorders, such as anxiety and panic, or related problems, such as managing stress and shyness. All these approaches indicate quite clearly that the emphasis is on defeating the enemy of depression, or other mood disorder or problem, through a variety of tactics. As such, these various voices present a unified perspective on depression. While details may differ (sometimes substantially), they represent, in reality, one voice; and all use a common storyline of ascent. Certainly, these other voices do not constitute ‘inconvenient voices’ questioning the ascent storyline, as they are all concerned with ascent away from, or out of, depression. There also tends to be a common emphasis both on the responsibility of individuals to address depression with the help of professionals and on the provision of tips and exercises to help individuals improve thinking and behaviour as ways of combating and overcoming depression.

For example, Rowe’s classic book on depression (2003) was first published in 1983 and is now in its third edition. As with *beyondblue*, Rowe is also concerned to help people get rid of depression and, though emphasizing counselling over medication, provides a considerable amount of information and helpful advice. Although Rowe describes depression not as an illness but as a result of negative life experiences, she, nevertheless, sees it as a prison individuals need to leave if they are to lead happy and fulfilling lives. Also emphasizing a cognitive approach to various mood disorders, including depression, Edelman (2002) sets out practical steps and exercises to overcome negative thoughts and feelings. The bestselling book by Dowrick (2005) is focussed on happiness and ways to overcome obstacles to

happiness through improving thinking and interpretation. Parker (2002) has written an informative book about depression, detailing the types of depression, the treatments available, and emphasizes the importance of correct diagnosis so that the treatments match the types of depression. Easy-to-read books are also available that present the same sort of information and advice about depression in a very pared-down format. Both employing the image of depression as a ‘black dog’ and describing how to manage it Aisbett (2000) has employed a cartoon style approach while the Johnstone husband and wife team (2008) have utilized a picture-book format. Even books from a religious perspective (Anderson & Anderson 2004, Biebel & Koenig 2004) that recognize the gifts and value of depression and suffering (see 8.5) still promulgate the dominant approach to depression of diagnosis, treatment, and recovery.

There are also numerous websites on depression that provide helpful information, though often emphasizing different aspects. For example, the *Black Dog Institute* has a strong focus on the necessity of correct diagnosis, detailing the types of depression and the various sorts of treatment available. The *BluePages* website also focuses on evidence-based treatment for depression. The *CRUFAD (Clinical Research Unit for Anxiety and Depression)* website offers self-help information for those suffering from anxiety and depression as well as information for health professionals. The *Health and Wellbeing* section on the ABC (Australian Broadcasting Corporation) website also includes a depression page providing information on depression symptoms, types, and treatment. Interestingly, *JAMA* also provides a consumer page on depression (Torpy *et al.* 2008) that, not surprisingly, gives a simple and direct summary of depression symptoms, types, and treatments minus the differences of opinion evident in the professional medical literature, including in *JAMA* itself.

These are but a very few examples of the type of material produced for the public domain about depression and other mood disorders. All these voices speak about depression in the same way, following a common storyline of a journey of ascent. While their approach and emphasis may vary, they all view depression as something to be treated and overcome. The approach is always one in which Other must be reduced to Same. The journey is always and only one of ascent to a destination of recovery. The message of ascent from depression characterizing the public

orientations is pervasive, and is promoted from many sources. For example, articles detailing information from and about *beyondblue* in the area of depression and well-being can be found in sources as diverse as *The Independent Retiree* magazine (Young 2006), *The Australian* newspaper (Gallop 2007), the University of Murdoch's Alumni *Intouch* magazine (Pryer 2008), and *The Highland Digest* rural newspaper (Shoobridge 2009). While the ascent approach to depression is understandable, it is, nevertheless, an extremely restricted approach (see 8.4.2). Depression is presented as an illness that requires medical treatment, and there is no consideration that it is not an illness. That depression could be viewed in any other way than the medical one of diagnosis and treatment is absent; that depression could have meanings beyond interpretation and causality is also absent.

The 'inconvenient voices', particularly those discussed in Chapter Seven (Meaning Orientations), stand as reminders of other possible approaches to depression. However, in the public orientations to depression, as evident in *beyondblue* and other public domain literature, such 'inconvenient voices' are, if not entirely absent, so very absent as to be only found by those actively searching for them. To do this, an awareness of the possibility of other perspectives is required before such searching can even begin. In effect, this results in the 'inconvenient voices' in the public domain being absent from the public orientations, even though in actuality they do exist in the public domain: the 'inconvenient voices', then, are missing, but not lost.

## **8.5 Where Have the 'Inconvenient Voices' Gone?**

The medical and sociological literature about depression is full of 'inconvenient voices' simply because of the great variety of opinion and the many disagreements (Ellis *et al.* 2004a, Parker 2004a, Ebmeier *et al.* 2006). In both the medical and sociological literature this disagreement is variously tolerated or not, but there is generally some sort of acknowledgement of the existence of different opinions and perspectives. Of a somewhat stronger type, are the 'inconvenient voices' that call for a re-thinking and re-evaluation of current dominant ideas about depression (Pilgrim & Bentall 1999, Williams 2000b, Dowrick 2004, Kangas 2004, Blazer 2005, Horwitz

& Wakefield 2007), that even point to the flawed medical basis of public depression campaigns (Summerfield 2006a), or that speak to the complexity and difficulty involved in actually living and dealing with depression (Karp 1996, 2001, 2007). In addition, as discussed in Chapter Seven, there are ‘inconvenient voices’ *par excellence* that offer such radically alternative approaches to depression and suffering as to be wholly subversive of dominant paradigms (Rilke 1966, Wilson 2008). None of these types of ‘inconvenient voices’ are to be found in the material on the *beyondblue* website, or in the majority of material written for the general public. This absence, while understandable (see 8.4.2), is indicative of a sort of loss.

### 8.5.1 Casualties

The attempt to present to the public the subject of depression as clear and understood when it is not, and, indeed, when the subjected is heavily contested and even confused, results in the ‘inconvenient voices’ becoming casualties of this process. Parker’s (Williams 2007b: 3, quoting Ed Murrow) words are particularly pertinent: “[a]nyone who isn’t confused doesn’t really understand the situation”. Attempting to make Other into Same is always problematic, no matter how well the attempt has been designed and executed. This difficulty was clearly understood by Gary McDonald, one of the ambassadors for *beyondblue*, when, commenting on depression, he said, “I think the trouble is most people want a simple solution ... [and] there isn’t really an easy solution” (Mitchell 2008b: 10). Indeed, there tends to be a variety of solutions, a multiplicity of answers: this is the “trouble with life” – it “isn’t that there is no answer, it’s that there are so many answers” (Mead 1966: 189, quoting Benedict). The ‘inconvenient voices’ safeguard this fact and ensure the existence of a plurality of solutions and answers.

The ‘inconvenient voices’ are casualties of trying to make a complex and plural world simple and singular, and are not confined to the subject of depression. The missing ‘inconvenient voices’ are symptomatic of a total world-view, operating as if plurality did not exist in the contemporary secular West, combined with a Western rationalist emphasis on defining and solving the problem and determining cause and effect through investigation and explanation. The cost of presenting a perspective on

depression such as that to be found on the *beyondblue* website and in most other material on depression produced for the general public is the loss of ‘inconvenient voices’. The ‘inconvenient voices’ are missing from the public orientations to depression because, in pointing to the possibilities of other perspectives, interpretations, and meanings, they do not fit the crucial criteria of ascent. This lack of ‘inconvenient voices’ in the public orientations to depression is, I suggest, problematic for the public. You cannot know something is missing if its existence is not known about, or at least suspected, in the first place; and if it is not known that something is missing and apparently lost no search will be made for it. Although, these ‘inconvenient voices’ are not entirely lost, they must be actively sought after.

The public domain does consist of many ‘inconvenient voices’ that speak of other ways of perceiving depression, but the public orientations to depression have effectively pushed these so far to the edges that many will never discover them. Perhaps only those who have tried the medical approach and found it wanting will actively pursue other possibilities. However, such ‘deconversion’ experiences (Karp 1996) may not necessarily result in the discovery of other ways of considering depression. For example, many books, particularly religious and spiritual books, that do discuss alternative ways of understanding depression and ways to grow through and value the experience (Greenspan 2003, Hermes 2003, Anderson & Anderson 2004, Biebel & Koenig 2004, May 2005) present such material alongside the medical material as virtually an adjunct. Useful as these perspectives may be, and while partially inconvenient to the dominant medical paradigm of depression, they do not actually provide alternative perspectives to the medical perspective. Thus, individuals turning to such books will actually be led back to the medical approach to depression – such is the pervasive and potent influence of the Western medical paradigm of depression.

### **8.5.2 Implications**

The missing ‘inconvenient voices’ in the public orientations to depression create specific implications for individuals. While there are materials available in the public domain that destabilize the idealistic viewpoint on depression presented by

*beyondblue*, they are likely only accessed by some of the general public. On the one hand, public doubt and distrust of the medical model of depression and medical professionals is recognized as a problem in medicine that urgently needs addressing, and, on the other hand, this doubt and distrust is simultaneously ameliorated, if not eroded, through public initiatives such as *beyondblue*. Increasing the public literacy about depression is only reflective of a literacy defined by the medical paradigm. In other words, it is reflective of the successful infiltration of the medical paradigm into the public consciousness, and not of a greater understanding of the meaning of depression as part of the human condition.

The Western emphasis on happiness, the “imperative of ‘obligatory happiness’” (Rowe *et al.* 2003: 693, quoting Wierzbicka), and success gravitates to an ethos of ascent, particularly in matters of suffering and pain. In Chapter Three, I demonstrated that while descent into suffering was also part of the Western journey with suffering there has always existed a strong emphasis on ascent from suffering. In the contemporary West, the former approach has been pushed so completely to the edges, under the domination of the latter approach, as to be almost non-existent. At its worse, this focus on ascent from unhappiness can result in

the push for an endlessly ‘happy meal’ – a ‘McDonaldized’ (Ritzer 1995, 1997) recipe dished out to the masses in handy ‘bite-sized chunks’ (Městrović 1997). (Williams 2000b: 572)

The *beyondblue* website reflects perfectly this concern with ascent out of suffering and the absence of any sense that descent into suffering may have value. In limiting the public orientations to depression to only one possibility is to rob people of the possibilities of other journeys. While some may eventually find these for themselves, others (perhaps many), through factors such as lack of skill, education, or financial resources or belief in the Western emphasis on happiness, will not find these other possibilities. In addition, other demographic factors, such as ethnicity and rural isolation, are also likely to impact on those who are able to search for alternative ideas about depression and those who are not. Even those that are aware of the complex issues surrounding depression and its treatment, may conclude that they need the drugs in order to cope with contemporary Western life: “‘It’s the



postmodern ... dilemma.... We all know the drugs fuck your brain, but you need them to get on with your life'” (Bell 2005: 2, quoting Angie). Or they may decide, without necessarily being aware of the influence of culture on their individual situation, that they need medication, whatever its ambiguities and problems, in order to live, work, and relate to family and friends (Karp 1996, 2007).

There is a clear emphasis on educating the public about depression through initiatives like *beyondblue*. Such education, however, is implemented according to the perspectives and agendas of the medical profession, rather than on promoting a public awareness and discussion of an inclusive approach to depression. It is interesting that between December 2007 when I conducted my research of *beyondblue* and June 2009 when I perused the web pages to ascertain if there had been any major changes, I discovered that the control over, and the number of, personal stories from the public had changed. Advice is now provided on length and topics for discussion and considerably fewer personal stories are listed. Moreover, personal stories listed in 2007 (at ‘Personal Experiences’ – ‘People with Depression’) that advised against taking medication for depression (for example, the story by Helen on pages 15-16) and described the positive benefits of experiencing depression (for example, Jane on pages 5-7) are now absent. Stories, however, that spoke of the difficulty of admitting to having a depressive illness, the value of medical treatment, and the benefits of recovering from depression (for example, the story by Anne on pages 1-2 and the story by Michelle on page 2) have been retained on the 2009 ‘People with depression’ web page.

Research into lay narratives is a complex area of study (Shaw 2002, Lawton 2003, Prior 2003, Shaw & Woodward 2004a). Whether, by how much, and in what ways depression lay narratives can exist as separate discourses to the dominant discourses, given the pervasive influence of the dominant paradigm of depression advocated by the majority of resources on depression available in the public domain, is the subject of disagreement and continued research (Karp 1996, 2001, 2007, Pilgrim & Bentall 1999, Kangas 2001, Rowe *et al.* 2003). One area that was initially thought to provide an avenue for the development and strengthening of lay illness narratives was the internet (Hardey 1999), but this has since shown to be clearly promulgating the medical paradigm (Nettleton *et al.* 2005). This is no doubt due, in part, to efforts by

general practitioners to direct patients to reputable and appropriate websites such as *beyondblue* so that “(mis)information” available on other websites does not confuse them (Bishop 2002). It is noteworthy that the depression websites rated as having the highest quality of content (Griffiths & Christensen 2002) tend to be affiliated or associated with hospitals, universities, or government. For example, CRUFAD has links to the University of New South Wales and St Vincent’s Hospital, *BluePages* to The Australian National University, the *Black Dog Institute* to the University of New South Wales and the Prince of Wales Hospital, and *beyondblue* to various governments and research bodies. The advantage of such associations is the provision of quality material; the disadvantage is that such material is restricted by the health professional approaches to depression. However, there is some evidence that social health movements (Brown & Zavestoski 2000, Hess 2004, Allsop *et al.* 2006) can influence health professionals.

There are ‘inconvenient voices’ that can be found in books, articles, media stories, and television programmes. The information in such material can often combine both dominant ideas and alternative ideas. For example, media stories not only carry the message of organizations such as *beyondblue*, but also disseminate a variety of other information about depression and treatments that both challenge and support the dominant tenets in the public orientations to depression. Examples of such media stories would include: findings that antidepressants may harm male fertility (Aldous 2008); reports about the decline in Australians’ sense of wellbeing (*The Australian* 2006), and about the problematic issue of the placebo effect (Swan 2004); positive reviews of books such as Wilson’s *Against Happiness* (*The Australian* 2008); and discussions about the difference between sadness and depression (Elder 2007), about suffering (Kohn 2007b, 2007c), about happiness / unhappiness (Carleton 2005, Rutledge 2006, Kohn 2007a, Mitchell 2008a), about ancient cultures, the self and depression (Toohey 2003), and about medicalization, mental health and Buddhism (Rutledge 2002). While such material in the public domain adds to the overall information relating to depression and related topics it does not contribute to the education of the public in the way that the health professionals conceive of such public education. In this sense, the prescriptive approach adopted by *beyondblue* tackles the problem of such disparate and often contradictory information and opinion by focussing on one point of view, and ignoring the rest.

Nevertheless, the single point of view approach negates other possibilities. A challenging proposal is voiced by Veatch (2009: 257) in his argument for medicine to assume a new role alongside the patient in which the idea that ‘doctor knows best’ and the concomitant requirement of the patient to ‘follow doctor’s orders’ is replaced by the notion that “[d]octor no longer knows best”. Such a possibility is unlikely in the near future, however, given the position and attitudes of health professionals in contemporary Western society or given the fact that at times an ill person may gratefully and willingly follow “doctors’ orders” (Lawton 2003: 34). Yet, the presence of ‘inconvenient voices’, though essentially absent from the public orientations, do indicate a residual presence of alternative perspectives that offer other choices for the individual.

In order to accommodate a wider perspective, while not detracting from its main mission, perhaps *beyondblue* could consider a sub-section on its website entitled ‘*withinblue*’. This could examine the positive experiences, extraordinary benefits, and profound values of depression where people, though recognizing the terrible and continuing pain of depression, nevertheless, come to understand, as Rilke did, that “‘If I lose my demons, I will lose my angels as well’” (Berlin 2008: 4). While such a section would not be in line with its dominant medical approach to depression it would, however, be inline with its stated ‘Principles for action’ listed under ‘Our Mission’ that purport a “respect for human rights and dignity” (point 1) and recognize “diversity and special needs” (point 4). Perhaps, in this way, the possibility that human fragility can be embraced as part of what it means to be human, rather than rejected, and that the “contemplation of the world” be decreed as something beautiful and valuable, rather than as “sickness, depression, [and] maladies” (Flanagan 2006: 3), can be included as ‘an-other’ approach in the public orientations to depression.

## 8.6 Conclusion

In this chapter, primarily through an examination of the *beyondblue* website, I utilize Weberian concepts of a total world-view and the role of the elite, the Derridean

concept of the centred interpretation, and Levinasian concepts of Same and Other to explore how depression is presented to the public, what options they are given, and what information they are provided with. I also examine where these aspects differ from, and align with, the medical and sociological literature and discuss the implications of such differences and similarities. In summary, this material represents a simplified version of the medical approach to depression, with a few inclusions of sociological insights, presented in such a way that it seems a straightforward and uncomplicated *fait accompli*. Although post-modernism supposedly facilitates choice, the general public are presented with few choices in how to view human sadness and what is to be done about it. The emphasis on ascent from depression strongly reflects the ‘ascent’ polarity of the ‘descent / ascent’ motif of suffering discussed in Chapter Three (3.5).

Elements of Plato’s attempt to define what constitutes the human condition and to then control it, or banish those parts that do not fit, and his emphasis on the necessity of the elite to correct the misguided general population are evident in the public orientations to depression. Similarly, the simplistic nature of the approach to suffering epitomized by Job’s friends is also apparent in the public orientations to depression promoted by *beyondblue*. The embracing of descent into suffering, and the complexity that this necessarily entails, as exemplified by Job, Aristotle and the ancient Greek tragic poets and as evident in the secular atheistic literature and some Christian hymns examined in Chapter Three, is completely absent from the public orientations to depression found on the *beyondblue* website. Indeed, notions that through descent into suffering ascent out of suffering is achieved and that in such engagement with suffering can arise what is noblest in the human person, as argued by the tragic poets and Aristotle and experienced by characters such as Dr. Rieux (Camus 1960), are entirely contrary to the ethos of *beyondblue*. Also absent in the message about depression presented by *beyondblue* is the idea that experiences of descent into suffering, as understood by Job and promoted by Frankl (2004), can be meaningful.

The idea that the failure of Job’s ‘friends’ to actually help, despite the certainty of their knowledge, could be reflected in the difficulties and feelings of helplessness the medical profession can sometimes face in treating patients (Kutz 2000) is alien to the

‘doctor knows best’ message in the public orientations to depression promulgated in *beyondblue*. The poignancy of this is not that in the public orientations to depression the emphasis on ascent does not have benefits but that recognition of the value of descent is excised, even as doctors sometimes struggle to successfully treat their depressed patients.

In the contemporary Western framing of depression are to be discovered a number of layers. There is the layer comprising the professional medical and sociological literature; there is the layer comprising opinion from other fields, such as history, philosophy, and religion; there is a layer comprising ideas from the arts, such as poetry; and there is a layer comprising the public understandings of depression, which are largely determined by material about depression devised by the health professionals for public consumption. The latter is the public face (the common narrative) of all the other layers, some of which, as well as some aspects of which, are dominant. The public orientations to depression, because of the historical, interpretative, and meaning orientations to depression, are constituted with certain a content, have assumed a certain form, and therefore provide a certain answer. This is characterized by a particular perspective emphasizing one journey with one destination that has been divested of disagreements, differences of opinion, and ‘inconvenient voices’. Such an answer is one answer, but the existence of ‘inconvenient voices’ indicates that there are other answers. However, the possibility of plurality of answers is effectively resisted. The public orientations to depression are thus characterized by a restricted and simplified view of depression that is not found in the orientations discussed in the previous three chapters. Moreover, research into the experiences of those living with depression and caring for those with depression indicates quite clearly that there is not a simple map, nor a precisely delineated destination, nor a straightforward journey. Rather, there are not really any maps, the destination is uncertain and ambiguous, and the journey is complex, fraught, exhausting, and confusing (Karp 1996, 2001, 2007).

The Procrustean bed is seductive in its sameness, predictability and control, but dangerous for what it does to difference that will not fit within its specified parameters. The difficulty of educating the public about depression and avoiding the dissemination of material that is likely to confuse and bewilder accounts for the

authoritative and simplified perspective on depression offered by *beyondblue* and in much of the material about depression produced for the public domain. The presentation and promotion of a total world-view or a Rousseauistic Interpretation is a far easier task when the destabilizing factors that could threaten the homogeneity of such a total world-view or centre are effectively removed, or are at least ignored. In this way, the disruptive influence of the faces of Other are controlled by their reduction to a simplistic and highly controllable Same. The presentation of material about depression that is contrary to the public orientations to depression, but that still exist in the public domain, have been so isolated from the dominant voices that they appear to be lost. However, as expressed by *beyondblue*, there is a recognized need to respect human rights, diversity, and special needs. This raises an important question: do not the mission statements of *beyondblue* indicate a moral responsibility to provide ‘inconvenient voices’ about depression to the general public? There are disadvantages and advantages to both affirmative and negative answers, as my discussions in this chapter have indicated; however, such a question, difficult though it is, still needs to be given voice.

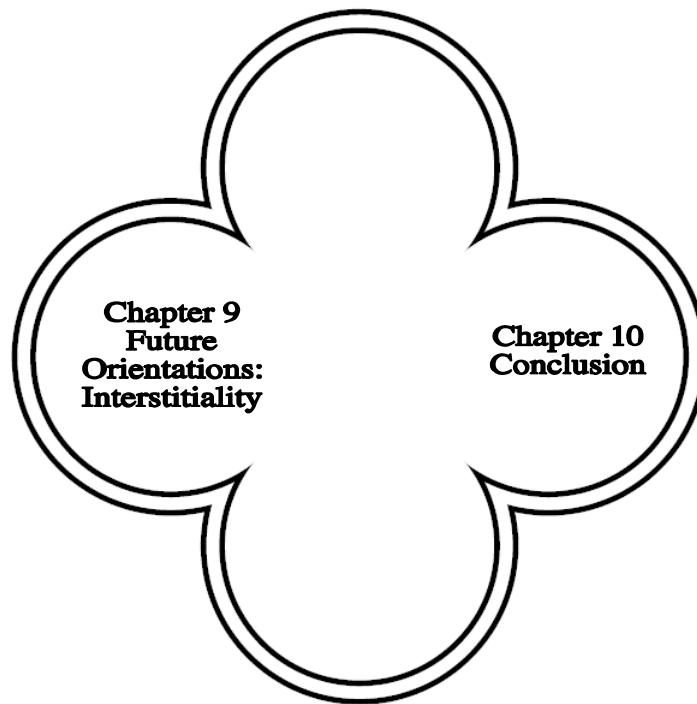
The problem confronting us all, not only in the area of depression, is how to respectfully accommodate difference and ‘other’ while at the same time valuing the benefits afforded in each of the often disparate perspectives. It seems to me that “‘maladjustment’” (Wallis 2008: 53, quoting Martin Luther King, Jr.), rather than adjustment, in the form of ‘inconvenient voices’ (both the questioning ones as well as the radically subversive ones) is what is needed to facilitate respectful dialogue between differing voices. It is fortunate, then, that the ‘inconvenient voices’ are only missing from the public orientations to depression and are not lost altogether. The possibilities for both respectfully affirming the value of the contemporary Western paradigm of depression as well as facilitating alternative perspectives is the subject of the next chapter.

## Part Three

# Conclusion

**There is no end to our investigations.... It is a sign of failing powers or of weariness when the mind is content. No generous spirit stays within itself; it constantly aspires and rises above its own strength. It leaps beyond its attainments. If it does not advance, and push forward, if it does not strengthen itself, and struggle with itself, it is only half alive. Its pursuits have no bounds or rules; its food is wonder, search, and ambiguity.**

(Michel de Montaigne)<sup>1</sup>



**Chapter Nine** explores how orientations to depression might be expanded in the future.

**Chapter Ten** concludes my discussions concerning the contemporary Western framing of depression on a matter of paradox and a note of humour.

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<sup>1</sup> Monatigne 1958: 348

# Chapter Nine

## Future Orientations: Interstitiality

**I ... let the other define herself ('Don't think you know the other without listening'); compare equal to equal (not my positive qualities to the negative ones of other); and find beauty in the other so as to develop 'holy envy'.**

(Krister Stendahl)<sup>1</sup>

**What we need ... is respect for the beliefs of others and the readiness to look for truth in what strikes us as strange or foreign.**

(Joseph Ratzinger)<sup>2</sup>

**So immune can we all become to otherness that we are tempted to reduce all reality to more of the same.... Every discourse ... necessarily excludes other assumptions. Above all, our discourses exclude those others who might disrupt the established hierarchies or challenge the prevailing hegemony of power.... But only by beginning to listen to these other voices may we also begin to hear the otherness within our own discourse.... What we might then begin to hear ... are possibilities we have never dared to dream.**

(David Tracy)<sup>3</sup>

### 9.1 Introduction

This chapter explores possibilities for ways in which approaches to depression in the future, which I term 'future orientations', can be enriched by expanding on the ideas of Weber and Derrida used in this thesis (see Chapter Four: 4.2.5). Through the concept of 'interstitiality', I propose that, in the future, orientations to depression be characterized by coexistence and respect, whereby 'other' can be valued and difference can be promoted. I envisage this as the means of bridging the gaps

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<sup>1</sup> Landau 2008: 2

<sup>2</sup> Huff 2008: vii

<sup>3</sup> Tracy 1987: 15, 79



between the Weberian irreconcilable rationalities and value spheres and finding the common ground of the two Derridean interpretations. While these future orientations to depression are influenced by the historical, interpretative, meaning, and public orientations to depression, they are not fixed in a pre-determined manner by them. Drawing on material about how the West approaches suffering (Chapter Three), how historical antecedents determine perceptions of depression (Chapter Five), how interpretative and meaning orientations to depression currently manifest (Chapters Six and Seven), and what orientations are made available for the public (Chapter Eight), in this chapter I posit some possibilities for future orientations to depression by also drawing on how ‘other’ has been treated in the past and today.

Depression (at the nexus of mind and body, reason and emotion) is a borderland experience: that is, it can be interpreted and explained via a variety of ‘stories’. It can be approached on the basis of scientific rationality (Ebmeier *et al.* 2006); it can be approached as an example of how normal sadness has been medicalized (Horwitz & Wakefield 2007); it can be approached through the individual stories of those struggling to make sense of depression in their lives (Karp 1996, 2007); it can also be experienced and understood in spiritual / existential ways (Rilke 1966: 163-209). In addition, there is any number of other ‘stories’ about depression. However, it is the medical ‘story’ of depression that is clearly dominant in the contemporary West. To allow for only one ‘story’, only one territorial claim, is to diminish the broad territory that is depression. Border skirmishes and areal invasions cannot result in the respectful coexistence of difference. Rather, respectful dialogue is needed and a commitment to coexist *with* difference (*with* the ‘other’), not *against* difference (*against* the ‘other’). The medical ‘story’ significantly influences the unfolding of the individual stories of those living with depression and those caring for them (Karp 1996, 2001, 2007). A greater inclusivity, of possible directions to take in negotiating the depression terrain and possible ‘storylines’ about depression to try, facilitates and legitimates a greater choice for how such people determine which directions to take and which ‘stories’ are most suitable as they live out their *own* unfolding ‘stories’.

If the human being were a ‘machine’ then science would be master, but the human being is not a machine. Rather, the human is an unquantifiable conscious being existing both within and without the parameters of scientific rationality. Depression

constitutes a part of human suffering. In restricting approaches to, and understandings of, such emotional suffering within the parameters of mental illness is to disallow ‘other’ approaches and ways of understanding it. What is needed in the future is not only a way of accommodating different ‘stories’ about depression but also a way of encouraging the cessation of the quest for the unity of perspectives via the creation of one correct perspective. In this chapter, I pursue such an objective by first giving an overview of my discussions concerning the contemporary Western framing of depression, proceeding to an examination of the treatment of ‘other’, and concluding with suggestions for future orientations to depression.

## **9.2 Depression in the Contemporary West**

My examination of depression in the West is one perspective among many. It is neither comprehensive nor definitive, and attempts only to be suggestive of another way of viewing depression. During the course of my research, I found contemporary approaches to depression to be both valuable and restricted, and to be characterized by plurality, disagreement, and contestation. Based on this situation, I concluded that a wider perspective would not only facilitate the inclusion of ‘other stories’ about depression, currently excluded from the dominant paradigm of depression, but would also be best characterized by mutual respect. While I had found Weber and Derrida particularly useful for my study, I was not satisfied with where the application of their ideas left my examination of depression. I decided that I would need to extend their thoughts in order to bring my discussions about depression to a conclusion that offered positive possibilities for future directions.

### **9.2.1 The Story So Far**

As a first step, I will summarize my examination of depression as this, necessarily, is the starting point from which any suggestions I proffer about future possibilities must begin. In the preceding four chapters I examine different but interconnected aspects of approaching the subject of depression, which I term historical, interpretative, meaning, and public orientations. Together, these orientations, constituting the four

main ‘leaves’ of the Quatrefoil Model of Historical-Cultural Framing, provide a lens through which to examine and understand the contemporary Western framing of depression. In addition, I discovered that each of these orientations reflected one of the Motifs of Suffering I discuss in Chapter Three, displaying an emphasis on the polarities of certainty, resistance, causality, and ascent.

In Chapter Five (Historical Orientations: Certainty), my examination of the depression literature reveals that contemporary approaches to depression in the West are framed by orientations to the world inherited from the past. These are largely *a priori* in nature and, as such, can be difficult to see. Nevertheless, I demonstrate that approaches to depression are characterized by a total world-view (predominantly the medical-scientific view) that bestows a belief that there is one true and correct way of viewing and understanding depression, by which it can be analysed, mastered, and therefore controlled. This emphasis on certainty of viewpoint and mastery is no more evident than in EBM, through which the health professionals largely determine how depression is approached, diagnosed, and treated. Also inherited from the past is the emphasis on the role and power of the elite (the health professionals) and their authority over the laity (the general public). However, the presence of plurality, reflected in conflicting views about depression (both within and without medicine and sociology) and in the form of ‘inconvenient voices’, disrupts this total world-view. Nevertheless, the emphasis on certainty and the efforts to control the chaos of depression clearly situate the historical orientations to depression at the ‘certainty’ end of the ‘chaos / certainty’ motif of suffering explored in Chapter Three (3.4).

Chapter Six (Interpretative Orientations: Resistance) constitutes my exploration of the depression literature to determine how depression is interpreted. The interpretative orientations to depression, with the exception of some strongly questioning ‘inconvenient voices’, are characterized by a problem and solution approach in which depression is viewed as something to be resisted. This emphasis on resistance strongly locates the interpretative orientations to depression at the ‘resistance’ end of the ‘acceptance / resistance’ motif of suffering discussed in Chapter Three (3.2). The idea that maybe depression could be accepted is barely hinted at in even a few of the ‘inconvenient voices’. Under the influence of the historical orientations, depression is viewed as a problem that needs to be correctly

defined and correctly solved. As a result, the interpretative orientations are strongly linked to a belief that there is a correct way to define and solve the problem of depression and that if this is achieved then depression can be resisted effectively.

My examination of the depression literature in Chapter Seven (Meaning Orientations: Causality) indicates that the meaning orientations to depression are directly related to the historical and interpretative orientations to depression. Due to the emphasis in the West on rationality of a scientific type, the meaning orientations to depression are narrowly confined to concerns with causality. Depression is viewed firmly as ‘other’ that must be controlled through investigation and explanation. However, the presence of many ‘inconvenient voices’, from the minor ones to the radical ones, upset the pursuit of, and emphasis on, causal meaning. Indeed, the most inconvenient of these voices completely upturn the dominant Western approaches to depression by revealing that the meaning of depression could be one of relationship, rather than one of cause and effect. The circumscription of meaning to causality positions it at the ‘causality’ end of the ‘relationship / causality’ motif of suffering explored in Chapter Three (3.3). The focus on the causal meanings of depression alone, and the effective closure or restriction of routes to alternative meanings of depression, creates a significant problem for meaning in the contemporary Western framing of depression.

In Chapter Eight (Public Orientations: Ascent), my investigations of depression turn to the orientations to depression that are provided for the general public, and focus on *beyondblue*. I discover that these perspectives on depression represent a simplified form of the medical paradigm of depression from which have been removed all the disagreements, contestations, and uncertainties. While a broader understanding of depression is available in the public domain, this is not communicated in material specifically designed for public education. Locating this other material relies on awareness that it exists and knowledge about where to find it. In particular, the virtual absence of ‘inconvenient voices’ attests to the cleansing of the public orientations to depression of anything remotely contradictory to the idealized message about depression conveyed to the public. While such material is specifically designed to increase depression literacy, such education is restricted to a simplified version of the historical, interpretative, and meaning orientations to

depression, and as such, the public orientations to depression reflect the ‘ascent’ end of the ‘descent / ascent’ motif discussed in Chapter Three (3.5). Indeed, in the public orientations to depression the concept that descent into depression may be both an option and a choice about how to view depression is completely anathema.

These four orientations to depression characterize one way of approaching the subject of depression. Exploring these different but interrelated aspects of the contemporary Western framing of depression reveals a consistent approach to depression as ‘other’ that needs to be labelled, defined, diagnosed, treated, and eradicated and a consistent reaction to ‘other’ ideas about depression that results largely in their rejection. In addition, opinions about depression are often highly contested, even within the medical field. Nevertheless, overall, depression is seen as an illness requiring medical intervention. It is only the presence of ‘inconvenient voices’ that provide possibilities of viewing depression in ways other than those promulgated by the dominant paradigm of depression.

Viewing depression as an illness represents one way of understanding the emotional suffering that is now commonly referred to as depression, but it constitutes only one part of a much broader Western response to suffering. In Chapter Three, I briefly explore responses to suffering within Western culture as a means of gaining a broad historical-cultural background about suffering against which I could then situate the contemporary approaches to depression. Through a discussion of *Job*, ancient Greek literature, secular-atheistic literature, and Christian hymns and songs it is possible to gain some insight into the human journey with suffering in the West that helps provide a wider perspective on contemporary approaches to depression. In what I term Motifs of Suffering (‘acceptance / resistance’, ‘relationship / causality’, ‘chaos / certainty’, and ‘descent / ascent’) a tension between, on the one hand, recognizing and accepting the existence and value of suffering and, on the other hand, desiring and calculating the control and prevention of suffering emerge as consistent characteristics of the Western response to suffering. However, in approaches to depression in contemporary Western culture there is a significant waxing of the latter polarity in each motif and a notable waning of the former. The emphasis on certainty of the medical paradigm of depression, resistance to depression through its designation as an illness, investigation and explanation of the causality of depression,

and ascent away from depression corporately situate current approaches to depression very firmly at one polarity only in each of the Motifs of Suffering. The other ways that suffering has been approached in the West, represented by the opposite polarities of chaos, acceptance, relationship, and descent, are largely absent, to be found only in some ‘inconvenient voices’.

Contemporary approaches to depression, then, while valuable as representing one set of approaches to depression, are partial in terms of the wider perspectives of how the West has approached, and continues to approach, suffering. This means that alternative possibilities to the dominant health professional paradigm of depression, voiced by some of the ‘inconvenient voices’, are only to be found ‘at the edges’ for no other reason than they are different.

### **9.2.2 The Future Story: Where To From Here?**

The contemporary Western framing of depression, as the previous four chapters indicate, provides much valuable and insightful information and ideas about depression. In the medical field, for example, enormous developments in understanding depression have been achieved (Ebmeier *et al.* 2006), and future research continues in areas such as genetics (Bennett 2007), neuroscience (Joyce 2007), improvements to antidepressants (Barondes 2003), and advances in understanding the mechanisms of depression (Meyer *et al.* 2006). In sociology, fruitful research into depression encompasses areas as diverse as gender (Bracke 2000), ethnicity (Coker 2003), patient-doctor relationships (Malpass *et al.* 2009), the media (Rowe *et al.* 2003), patient and carer stories (Karp 1996, 2001, 2007), and medicalization (Horwitz & Wakefield 2007), to name but a few. From the broader medical and sociological fields topics such as narrative medicine (Charon 2006), the medicalization of society (Conrad 2007), and the examination of alternative medicine (Schraeder 2008, Singh & Ernst 2008) provide supplementary information useful for developing a broad perspective on depression.

In addition, from other fields, such as history, literature, philosophy and religion, research and ideas on a variety of topics provide additional aspects also useful for

application in how the West might approach and understand depression. These include, for example: melancholy (Radden 2000); happiness (Bstan-'dzin-rgya-mtsho & Cutter 1998); the meaning of life (Eagleton 2007); paradox (Easterbrook 2004, Hamilton 2008); philosophy of psychiatry (Radden 2004); broadening the current restricted concept of reason to include faith (Ratzinger 2006); Buddhism and personal growth (Welwood 2000); emotions and intelligence (Goleman 1996); poets, the creative process, and mental illness (Berlin 2008); and the mind-body connection (Harrington 2008). Together, all these 'stories' produce a rich and diverse plethora of ideas about depression, suffering, and the human condition. The diversity of such opinion and research, which provides so many possibilities for understanding and approaching depression, would be best served in the future by directions that embrace both inter-disciplinary and intra-disciplinary dialogue characterized by respect and the coexistence of different ideas.

It is perhaps difficult for medicine to enter into such dialogue and coexistence because of the force of Western rationalism and the strength of its total world-view approach. However, I consider that the field of depression would benefit from such approaches, and particularly needs to also include those ideas and approaches to depression that are wholly, or partly, antithetical to mainstream approaches to depression. It is not a case of 'depression as illness' versus 'depression as suffering', however, because the former is a constituent part of the latter. It is one perspective among other perspectives. That is, depression as a form of suffering is made up of many 'stories', one of which is the 'story' of depression as an illness. An inclusive approach would facilitate the appreciation of differing concepts about depression that could lead to "possibilities we have never dared to dream" (Tracy 1987: 79).

The way in which depression is approached in the future will stem very much from how it is approached today, but the future orientations, as depicted in my theoretical model (see Chapter Four: 4.2.5) are always 'becoming'; that is, future orientations to depression are constantly in a state of genesis. They are characterized by organic growth, rather than by pre-fabrication in concrete and steel. As such, while they are clearly determined by the present approaches to depression, how depression will be approached in the future is not, I suggest, definitively pre-determined. It is this essentially 'becoming' nature of future orientations that facilitates change and

possibility and creative potentiality. In the next section I will examine examples of how ‘other’ is treated before presenting my ideas about what might constitute future orientations to depression, that are both determined by the present approaches but are also endlessly open to future developments and possibilities. In particular, I have been concerned to deal directly with what I perceive to be a significant shortcoming in the contemporary Western framing of depression: that is, the ‘othering’ of depression as an illness, which tends to remove it from its place as a part of human suffering, and the rejection of approaches to, and opinions about, depression that are ‘other’ than those permitted by the dominant paradigm that views depression as *only* a mental illness.

Concepts drawn from Weber and Derrida proved valuable for the theoretical foundation of this thesis. However, in terms of providing a way forward from the irreconcilability of either rationalities or interpretations I feel “warring gods” (Weber 1991: 153) or an “unnamable ... infant” (Derrida 1978a: 293) are not the most helpful of concepts in a pragmatic sense. In considering how best to frame future approaches to depression I found it necessary to explore ways of moving beyond where Weber and Derrida leave us, and one issue seemed paramount: irreconcilability in our increasing global and pluralistic world is no longer an option. In many areas, the world is faced with urgent problems about how to address divisiveness and contestation. Total world-views and different rationalities and interpretations need to be reconciled in some way; they need a ‘common ground’ that is tangible and workable, but that still honours and validates difference. In my search for how to deal with this apparently insoluble challenge I sought out examples of where this problem is being constructively approached as a way of formulating possibilities for how depression might also be approached in the future, thus providing something of a signpost to answer the question, ‘where to from here?’

### **9.3 Treatment of the ‘Other’**

The task of examining how ‘other’ is treated presented a vast array of possibilities from which to choose, ranging from slavery, race relations, the treatment of women



and homosexuals, to views on the disabled and the insane. Therefore, in searching for material from which to draw on in the formulation of new possibilities for how depression could be approached in the future, I turned to Weber and Derrida for guidance in selecting the most relevant examples. As a result I became particularly interested in two facets of the treatment of ‘other’: firstly, the treatment of ‘other’ today where previously that ‘other’ was rejected; and secondly, where ‘other’ is still both rejected as wrong and dangerous or embraced as merely different.

My study of the contemporary framing of depression reveals it to be an example of a Weberian total world-view or Derridean centred interpretation in which the medical perspective is generally considered unilaterally correct. The source of the problem of how ‘other stories’ of depression are rejected or marginalized by medicine is in the inheritance by science, from religion, of this total world-view or centred interpretative position. Hence, I thought it would be enlightening to examine how Christianity, the former hegemonic total world-view / centred interpretation in the West, currently approaches other religions compared to the past as a way of developing an alternative approach in the future to difference and ‘other’ in the field of depression studies.

In addition, because Weber (1991: 147, 152) saw the divide between the different rationalities (*e.g.*, formal and substantive) and value spheres (*e.g.*, intellectual and religious) as “irreconcilable” and Derrida (1978a: 293) saw the division between the two interpretative positions as one of “irreducible difference”, I considered an examination of the current relationship between religion and science would also be instructive as to how to approach different points of view about depression in the future. I found both of these examples to be insightful for developing future ways of approaching depression because they are informative of difficulties in the West of dealing with the ‘other’ and of the ways that such difficulties are negotiated.

### **9.3.1 Changing Attitudes to the ‘Other’**

Christianity has a long and tragic history of intolerance for other faith systems and cultures (Pérez 2004), yet today there are many global examples of determined

efforts to approach other religions with respect and to engage in dialogue. While admittedly interfaith dialogue has a long journey still ahead of it, primarily due to extremist religious and conservative groups, the movement towards not merely toleration of other faith systems but active coexistence constitutes a radical shift in the Christian perspective. Even advocacy of the value and importance of dialogue between religious non-fundamentalist groups and religious fundamentalist and conservative groups has been “greeted with enthusiasm” by representatives from many religions (Huff 2008: 157).

The focus on respect for ‘other’ is central to the ethos of *The Council for a Parliament of the World’s Religions* (‘About Us’: 1), which was created to cultivate “interreligious harmony, rather than unity”, between the world’s religions and to promote dialogue and the nurturing of relationships “among people of difference”. Similarly, the *World Conference of Religions for Peace* (WCRP: ‘Press Release: Religious Leaders of Different Faiths Seek Peace through Dialogue’: 1) also respects religious difference and works to promote and celebrate our common humanity through an emphasis on dialogue while also recognizing that “we are very often called to relate with those with whom we disagree on highly important issues”. The *World Council of Churches* (‘Programmes’: 1) is likewise committed to inter-religious dialogue and cooperation because it recognizes that in “our increasingly pluralistic societies more inter-religious dialogue and cooperation are needed” and that the promotion of respect through dialogue is necessary to address “perceptions of ‘the other’”. These approaches towards harmony, rather than unity, respect difference but still seek coexistence. This concern with respect and dialogue can also be found in the United Nations declaration of 2009 as the International Year of Reconciliation to promote “dialogue among opponents from positions of respect and tolerance” (*United Nations General Assembly* 2007: 1), and in the planned declaration of 2011 - 2020 to be the United Nations Decade of Dialogue to promote and sustain interfaith dialogue and cooperation (WCRP: ‘News & Press’ – Press’: 1).

The emphasis in these examples is on respect, dialogue, and harmonious coexistence of difference. While “disagreement about truth is crucial to the health of our societies” (Coffey 2008a: 2, referring to Williams), Williams (2007: 2, 5) argues for the “paradoxical conclusion” that in a plural society “religious liberty” is secured “by

advocacy for the liberty” of those belonging to religious groups different to one’s own. Such opinion represents a clear example of where a total world-view (Christianity) has moved from attacks against the liberty of those holding different faiths to a position in which liberty is a reciprocal condition and where different total world-views are respected and coexistence between them sought. There has been an extraordinary movement towards the inclusion of ‘other’, rather than its destruction, respect for the ‘other’, rather than negation and insult, harmonious coexistence, rather than domination, and promotion of human dignity and rights, rather than coercion and slaughter. From many quarters, attitudes to ‘other’ now begin not from violence against anything different but from an acknowledgement of the “‘dignity of difference’” (Williams 2007: 5, quoting Sacks). In many ways, these changes represent the Derridean “common ground” of *différance* (Derrida 1978: 293) and the reconciliation of Weberian irreconcilable rationalities and value spheres. I suggest this emphasis on harmonious dialogue and cooperative relationship is a good example of how Christianity has transformed from a position characterized by a Weberian total world-view that is in contestation with, and seeks dominance over, other world-views to a position that respects other world-views and seeks coexistence with them.

### 9.3.2 The ‘Other’: To Reject or Respect?

In the relationship between science and religion two approaches are evident: rejection of the ‘other’ or respect for the ‘other’. For some there is a conflict between science and religion, where the latter is viewed as ‘other’ to be eradicated for the benefit of society and people, whereas for others there is no difficulty in embracing a harmonious coexistence of science and religion. For example, on the one hand, Hitchens (2007) and Dawkins (2006) pursue a vitriolic attack against religion, viewing it as dangerous and debilitating, and lauding science / reason as the great saviour of mankind. Science, from Dawkins’ point of view, “is the supreme cultural authority” that should and must replace religion (Crittenden 2007: 5). Even more acerbic than Dawkins, Hitchens (2007: 340, 6), who considers a “renewed Enlightenment” focussing solely on humankind is within everyone’s grasp, has produced an equally polemic attack against religion, arguing vociferously that it

“poisons everything” because it is corrupt, abusive, murderous, destructive, and repressive.

On the other hand, Ward (2006, 2008), McGrath (2004), and McGrath & McGrath (2007) defend the value of religion and Heller (2003) and Peacocke (2005) pursue an holistic approach that incorporates science and religion. There is a clear division between opinion that designates religion as the ‘other’, with science as the only rational and intelligent way to approach life, and opinion that does not see either science or religion as ‘other’ but views both as different expressions of understanding that can coexist. Even those who do not disagree with the arguments of Dawkins and Hitchens *do* disagree “with the atmosphere of their arguments ... [and] with fanning the flames of bigotry” (Adams on *Compass* 2009). Scientific rationalism, in its attacks against religion, “constitutes the latest phase in the West’s long history of domination by which it has sought to defeat every form of difference” (Beattie 2007: 10).

The productive and rewarding interplay possible from a dialogue between science and religion (Küng 2007, Campbell 2008, Consolmagno 2008, Polkinghorne & Beale 2009) is completely absent from a viewpoint arguing that religion is restrictive and damaging to human life (Dawkins 2006, Hitchens 2007). Küng (2007: 41) argues for the relationship between science and religion to be characterized, rather than by a “*model of confrontation*” or a “*model of integration*”, by

*a model of complementarity involving the critical and constructive interaction between science and religion in which the distinctive spheres are preserved ... and all absolutizings are rejected.*

Also arguing for a coherent view of science and religion, Heller (2003: 145-146, 156, xii) describes science and religion as meeting at a “horizon ... of Mystery” where the relationship is one of tension “between the ‘attitude of science’ and the ‘attitude of faith’”, but also one of “peaceful coexistence”. Similarly, Ratzinger and Habermas (2006), while arguing from entirely different perspectives, arrive at similar conclusions regarding “the essential complementarity of reason and faith” (Ratzinger & Habermas 2006: 79), the mutual benefits reason and faith afford each other, and the value of continuing dialogue between the different and distinct positions of

secular reason and religious faith. While there is an inevitability of “continuing disagreement” between these different groups, and the opinions they hold, there is also recognition for a “necessary relatedness” between these groups (Ratzinger & Habermas 2006: 50, 78).

Currently, the differing approaches to religion and science exemplify the divide between restricted approaches that exclude other positions and open approaches that include and respect antithetical positions. The fundamentalist position taken by those such as Dawkins and Hitchens echo the fundamentalist position of Christianity in the past (and also of fundamentalist Christianity today). “Scientists have taken over from Christian theologians the belief that they are custodians of the one and only truth” (Beattie 2007: 10). There is a clear dichotomy between those who reject ‘other’ and those who respect ‘other’. Winston, who considers that science and religion say different things and can coexist (Kohn 2006a), is condemnatory of Dawkins’ position (Williams 2007a: 2) because of its failure to recognize the need for “other people’s religious positions to be treated with the utmost respect”. This underlies the essential problem arising from a lack of respect for difference. Rejecting ‘other’, particularly in a vitriolic manner, leads to only more division and contestation; while respecting ‘other’ in a way that values the different qualities of each perspective leads to the possibility of harmonious coexistence and mutual benefit.

### **9.3.3 Approaches to ‘Other’**

These brief discussions raise crucial points to consider in the formulation of ways to approach depression in the future: attitudes to, and relationships with, ‘other’ can change (9.3.1); and disputes between one point of view and ‘other’ points of view are as potent today as perhaps they have ever been, but such contestation is unnecessary and divisive (9.3.2). These examples cogently suggest to me that increasingly the world is approaching ‘other’ with respect and seeking ways of harmonious coexistence through dialogue, but that perspectives operating out of what can be described as a Weberian total world-view or a Derridean Rousseauistic Interpretation are still powerfully in evidence today.

In summary, my research for this section indicates that there is considerable evidence for inclusivity of ‘other’, characterized by respect, the value of difference, the importance of dialogue, and an emphasis on the coexistence of ideas and opinions in place of an emphasis on unity. Equally, there is also evidence of authoritarian attitudes applauding one point of view to the exclusion and rejection of others. The ongoing religion / science debate presents two possibilities for the future: vitriolic divisiveness or respectful coexistence. I think that debate and discussion about depression in the future would be more beneficial and productive if the latter approach were adopted rather than the former. Positive and inclusive attitudes to the treatment of ‘other’ indicate future possibilities for how medicine could develop an approach to depression based on respectful coexistence of different viewpoints, rather than domination or rejection.

## **9.4 A Place and A Space For Tears**

In extrapolating from my observations and findings in the previous section, there are a number of factors that need to be considered in the formulation of any ideas about future approaches to depression. Discussions in this thesis have revealed certain characteristics of the dominance of the medical paradigm of depression as well as the presence of ‘inconvenient voices’. In the future I anticipate that depression will continue to be dominated by medicine, with some insights from sociology variously adopted / recognized.

In all likelihood, medicine will maintain its total world-view as the correct perspective on depression with the health professionals holding authority over the general public (Historical Orientations); will expand its emphasis on defining and solving the problem of depression (Interpretative Orientations) and determining the causality of depression (Meaning Orientations) through continuing research; and will persist in improving the depression literacy of the general public according to a simplified version of the medical paradigm of depression (Public Orientations). Nevertheless, the continuing presence of ‘inconvenient voices’, whether indicative of differences of opinion within the medical framing of depression or alternative

viewpoints, also indicates plurality of opinion and diverse research. This is a particularly healthy indication of the robust development of a variety of ideas about depression, despite the dominance of the medical framing of depression. I suggest that any future orientations to depression need to both value this dominant position as well as the existence of ‘other’ voices, and at the same time encourage movement towards coexistence of differing viewpoints to provide places and spaces for difference.

I consider the concept of ‘interstitiality’ to be the best way of facilitating and achieving future approaches to depression (future orientations) that are characterized by dialogue and reciprocity because it allows for difference to meet and preserves the integrity and separateness of difference. However, in order that such interstitiality leads to positive outcomes also necessary is the presence of respect and coexistence, despite the inevitability of continuing disagreement. In this way, the “sifting [of] the wondrous and irreducible diversity of our experience of the world into narrow grids and dogmas” (Beattie 2007: 10) can be circumvented. Respect facilitates places and spaces *between* the dominant voices and the other voices, thus ensuring not merely inclusivity, but respectful inclusivity: it is in this interstitiality that future possibilities have the greatest chance of developing.

Appropriating Gadamer’s concept of the ‘fusion of horizons’ (Habermas 1977, Pusey 1987, Gadamer 1990), I suggest that it is in an interstitiality of horizons, of the horizons of differing and often antithetical paradigms and orientations, that there exists the possibility of fusion. However, this is not a fusion of integration to form a single unified position but a fusion of the coexistence of difference (the Derridean ‘common ground’ of *différance*) in a continuing, inclusive, and respectful dialogic process of ‘becoming’. While such dialogue may tend to take place ‘at the edges’, it nevertheless fosters growth of new nexus, that perhaps are only possible ‘at the edges’. In the West, it is such liminal voices, not, unfortunately, always in respectful dialogue with the dominant voices, that sometimes have historically brought about, and continue to bring about, significant changes (the abolition of slavery, the rights of women, gays, indigenous peoples and the disabled, and the growth of inter-faith relations).

### 9.4.1 Interstitiality

Put simply, interstitiality is where difference meets: it is an ‘in-between’ place or space. An ‘interstice’ is an “intervening ... space” and, for example, in medicine refers to spaces between cells and tissues and in physics refers to spaces between ions and atoms (Brown 2002: 1407). In a rather more poetic and visual way, Swami Samnyasananda (Coffey 2008c: 14) describes an interstitial zone as a meeting point:

where water meets the earth and that is where the greatest life occurs either in a river but also in the ocean. You also have temporal interstitiality: an interstitial moment is a sunrise or sunset where times meet. And then you have a double interstitiality where you have a sunrise or sunset down at the beach.

Since depression is a subject for which there are different ‘stories’, ‘interstitiality’ as an umbrella concept for approaching depression seems an obvious choice. In addition, interstitiality describes the meeting of difference and the preservation of difference. For example, Swami Samnyasananda draws on interstitiality as a way of describing the Trika interfaith community in Melbourne where representatives of three faiths live together pursuing their respective faiths, but learning and growing from the interstitiality created by their coexistence (Coffey 2008c).

A future approach to depression based on interstitiality would value the various voices in medicine, sociology, and other disciplines as well as the ‘inconvenient voices’: not as a way of achieving unity but as a way of conserving difference and facilitating dialogue; not as a way of agreeing on a consensus point of view but as a way of sharing different points of view. The emphasis on preserving and valuing difference is foundational to global organizations such as the *Parliament of the World Religions* (see 9.3.1) and to inclusive approaches to the relationship between science and religion (see 9.3.2). Seeking a unity or synthesis of ideas about depression is as much reflective of a total world-view as rejecting any ideas outside the medical paradigm. In both cases, a singularity of perspective is sought rather than acceptance of plurality. The essential problem of restricting or excluding ‘other’ is that “[s]ingular and exclusive concepts of truth stifle plurality and difference” (Beattie 2007: 10). An interstitiality of different ideas also facilitates creative growth that can only arise where difference meets, and which cannot arise when ‘one’ seeks



domination over the ‘other’. As a concept, interstitiality maintains the integrity of difference but also represents a place and a space where difference can come together, learn, and grow. Merely coming together, however, does not necessarily ensure a good outcome. If interstitiality is to work as a concept, it needs to be characterized by coexistence and respect.

### 9.4.2 Coexistence

Globally the idea of coexistence is increasingly becoming a necessity. This is as important for people and the environment as for ideas. The variety of ideas about depression, some of which are seriously marginalized, indicates to me an urgent need to foster coexistence. Suggesting that those holding differing views about depression should coexist together may conceptually be a simple idea, but is practically often hard to accomplish. This is most particularly so due to the presence of a total world-view and the dominance of Western rationalism. Examples of the difficulty of coexistence, whether between ideas or peoples, can be found almost everywhere from the disagreements between politicians to the wars waged between countries to contested opinions regarding depression diagnosis and treatment. However, representatives of the world’s religions (9.3.1) are working hard to achieve such coexistence through a number of global forums, as are those advocating coexistence of scientific and religious ideas (9.3.2). The idea of coexistence of ideas about depression does not mean, however, that difference disappears or that disagreement, even conflict, is absent.

Coexistence does not deny argument and difference, but promotes dialogue from different points of view. For example, what is often seen as a debate between different perspectives on depression, represented by Ian Hickie and Gordon Parker (Parker 2004a, 2007, Ellis *et al.* 2004a, Elder 2007, Hickie 2007), signifies, at least in part, healthy dialogue and enriches our understanding of depression by presenting different cogently argued possibilities. However, the important point in such debates that can be learned from interfaith dialogue is that the sharing of different ideas is what is valuable, not trying to prove one perspective correct and others incorrect or faulty in some way. The *a priori* position running through this latter perspective

reflects a total world-view and the dominance of Western rationalism, and is the greatest impediment to the coexistence of a variety of different ideas and opinions about depression and to the mutual enrichment that can arise from such coexistence. The need to avoid being “dominated by one group proselytising one treatment versus another” is recognized, however, by some in the medical field (Cole 2007).

It would be beneficial to the field of depression to develop a *convivencia*<sup>4</sup> between the representatives of the various perspectives on depression. Examples of efforts moving in this direction would be endeavours to avoid the polarization between psychiatry and anti-psychiatry in groups such as the Critical Psychiatry Network, dedicated to improving mental health practice (Double 2002), and in the “spirituality and special interest group within the Royal College of Psychiatrists”, with an emphasis on the place, role, and value of spirituality in mental health and illness (Culliford 2002a). In addition, such a *convivencia* would help legitimate some perspectives on depression that are considered so ‘other’ (e.g., Rilke 1966, Moore 2004, Wilson 2008) as to be largely rejected from the contemporary Western framing of depression; not to legitimate them as ‘true’ but to accept them as different perspectives that contain their own truths. ““What we need is the willingness to look behind the alien appearances and look for the deeper truth hidden there”” (Huff 2008: vii, quoting Ratzinger). While some in Christianity have now learnt the value and necessity for coexistence of difference in the field of religion and some embrace the difference and value of both religion and science in a harmonious coexistence, these attitudes have yet to be fully appreciated and employed in the contemporary Western framing of depression.

### 9.4.3 Respect

Weber, Derrida, and Levinas, despite considerable differences in their ideas and concepts, all converge on one point: the importance of ethics, integrity, and respect. From Weber I draw on his emphasis on “intellectual integrity” (Weber 1991: 155) and an “ethic of responsibility” (Brubaker 1984: 109); from Derrida I draw on his

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<sup>4</sup> In the Iberian Peninsula during the early mediæval period Jews, Christians, and Muslims lived together in what is often referred to as *la convivencia* (the coexistence), designating the “cooperative and conflictual coexistence” (*Convivencia*: 1) of these three religious communities giving rise to an enriching exchange of ideas.

promotion of the “common ground” (Derrida 1978a: 293), the ethical nature of discussion (Kearney 1999), and through “the idea of hospitality ... the concept of unconditional openness” to other (Abbinnett 2003: 190); and from Levinas I draw on his focus on ethical respect for the Other, however it manifests, (Davis 1996) and on the ethical relationship between Same and Other (Peperzak 1997).

Although at times far from easy, the pursuit and practice of respectful dialogue is a far better option than the mutual and continual attacking of the ‘other’ viewpoint. The realization of this in hindsight, after years of non-dialogue where “to talk together and take another look at our material” would have obviously been the better option, is not merely unfortunate but disadvantageous to health professionals and their patients (Szasz 1994: 202). Unfortunately, medicine does not often allow for respectful dialogue open to ‘other’ possibilities with patients or other health or non-health professionals. Equally, sociology often does not always facilitate respectful dialogue, either.

Despite calls for scientists and social scientists to work together and dialogue (Cunningham-Burley & Kerr 1999, Middleton 2005, Middleton & Shaw 2007) this remains problematic. For example, recently Aronowitz (2008a) found that his discussions about the framing of illness using sociological ideas attracted rather negative responses (Fullwiley 2008, Kunitz 2008, Nathanson 2008), even though his intention (Aronowitz 2008b: 20) had been to avoid “either a turf struggle or a culture-wars-like debate about social construction, medicalization, and labelling”. Nevertheless, there are encouraging signs of movements towards respectful dialogue between, for example, health professionals and patients (McGrath 2002), and between the fields of spirituality and health (Peach 2003a, Koenig 2007, Wilding 2007) and spirituality and clinical care (Culliford 2002b, D’Souza 2007).

To facilitate even greater “complementarity” (Ratzinger & Habermas 2006: 79, Küng 2007: 41) between the differing approaches to depression, adopting a mindset of an interstitiality of coexistence and respect would considerably aid such an endeavour. Indeed, to develop an approach towards the ‘other’ of “holy envy” (Landau 2008: 2, quoting Stendahl) whereby value is sought in the ‘other’, not to be appropriated, but to be admired, would be an ethic supportive of both respect and

coexistence. As practitioners of interfaith dialogue recognize (9.3.1), seeking respectful coexistence will often result in dialoguing with those with whom disagreement is paramount over issues considered very important. However, it is the commitment to dialoguing in respect, with a mutual aim of peaceful coexistence, that needs to dominate all such encounters. To defend the right and liberty of a person to hold antithetical views I may not agree with is to recognize that in an interstitiality of respectful coexistence difference is the main characteristic. The rabbinical tradition of passionate debating over biblical texts is grounded in a respect for the subject under debate, a respect for the opinions of others, as well as a recognition that the debate and learning process is never definitive or completed (Sacks 2008). Similarly, I feel that in the future intense debate about depression could stem from respect for the subject and for the perspectives of others, underpinned by an acknowledgement that such dialoguing is an ongoing exercise without a definitive conclusion.

However, respecting the views of others does not *ever* constitute, in *any* circumstances, abrogation of duties and responsibilities to always uphold human rights and to always protect the vulnerable, the needy, and the disempowered. The ‘other’ may seem entirely alien, but there is a difference between that which is strange and that which is abominable. Without respect for the dignity and rights of other people, attitudes and actions can be paternalistic, at best, or abusive, at worst.

Respect operates ‘within’ and ‘without’ and ‘in-between’; that is, one’s own views should demonstrate respect as much as the views of others, and there should be a mutuality of respect for each other’s views. Indeed, there is as much a need for those perceived as ‘other’ by the dominant medical paradigm of depression to also respect the views of those occupying this dominant position as vice versa. Part of this reciprocal respect is also the ability to critique both one’s own ideas and the ideas of another, not in a quest to prove who is right but in a quest to coexist and share. It is the former (critiquing one’s own views and ideas), I suggest, that is perhaps more important for each to do. So often, opinion in research about depression can tend towards what is right with ‘my’ opinion and what is wrong with the ‘other’ opinion (Parker 2004a, Samarasekera 2007). Instead, it would be better to find what is worthwhile in the ‘other’ perspective and what is wrong with one’s own perspective. Moreover, the practice of seeking the ‘other’ within one’s own viewpoint can

meaningfully and usefully contribute to an appreciation and understanding of what constitutes the ‘other’ and how this ‘other’ in one’s own point of view is perceived as ‘other’ by those holding different, even antithetical, viewpoints. Such endeavours might also lead to new and unimagined possibilities in the future (Tracy 1987).

#### **9.4.4 Appraisal**

One particularly useful way of understanding how and why respectful interstitial inclusivity can facilitate and support more than one ‘story’ of depression is to use Weber’s concept of ‘elective affinity’ (Howe 1978, Kalberg 1980, Koch 1993). Although the meaning of this term is contested (Swedberg 2005) and Weber’s use of it is “diverse and moreover quite informal” (Howe 1978: 367), it nevertheless provides an avenue for appreciating *why* future orientations to depression based on interstitiality can provide a supportive place and space for honouring and valuing the various experiences of depressed people. In conceptualising this I am drawing on understandings of ‘elective affinity’ as “a condition of symbiosis, or mutual support, among two or more ideas, practices or institutions” (Koch 1993: 131), as existing between “certain legitimate orders and particular types of action” (Kalberg 1980: 1162), as ““compatibility”” (Swedberg 2005: 84), and as the “decisive conception” of relating “ideas and interests” (Gerth and Mills in Weber 1991: 62). In the application of ‘elective affinity’ to my topic of depression I am particularly interested in the ideas of ‘compatibility’ and ‘support’ for depressed people in the relationship between themselves and a doctor or an ‘other’, even depression itself.

A compatible relationship between doctor and patient, between the medical paradigm of depression as an illness and the patient’s need to be helped, is in evidence when a person visits a doctor suffering from depressive symptoms that are adversely affecting, for example, work and personal life. In the medical understanding of depression and the provision of medical treatment, whether drugs and / or counselling, an ‘elective affinity’ occurs for some people when the diagnosis given and the treatment prescribed remedies their emotional suffering and they are content with the results. Such individuals find a meaningful ‘compatibility’ between their needs and the doctor’s medical help because the treatment, as some of Karp’s (1996:

96) interviewees found, “was just magical.... It was a miracle. It really was. Quite extraordinary”. It also led to an appreciation (Karp 2007: 123-124) of how “incredible [it is] to discover who I really am” when taking medication and enabled a person to become “authentic in the most true sense”, as opposed to “totally unauthentic” when not taking medication. While successful treatment is not always immediate, for some it is eventually achieved, turning one poet’s writing, with the assistance of “changed brain chemistry”, “into art” (Porter 2008: 158). These depressed people, and many like them, have found great relief from their emotional suffering in the medical understandings of, and approaches to, depression. However, there are other people whom the medical profession describe as treatment-resistant. Despite years of trying one treatment option after another, they have found no ‘elective affinity’. For these people, this elusive search for a medical cure results in complete failure, yet they keep searching for effective treatment (Karp 2007).

Many others, however, find themselves on a long journey through trialling different drugs, searching for the ‘right’ doctor, and experimenting with different dosages (Karp 1996, 2007). Such people experience ‘elective affinity’ when finding the ‘right’ drug at the ‘right’ dosage under the care of the ‘right’ doctor. Sometimes, after decades of ‘mis-treatment’, a supportive doctor is found, who re-diagnoses and re-prescribes with positive results for life and career (Twichell 2008). In many ways, however, there is something of a fraught middle ground for many people between finding an ‘elective affinity’, perhaps losing it (for a variety of reasons, such as long-term drug incompatibility, dependence, or reduced benefits, wanting to get off the drugs, wanting to try a different drug, *et cetera*), searching for it, and maybe finding it again. This on-again / off-again ‘elective affinity’ provides intermittent compatibility and support interspersed with periods characterized by a reduction, or even a lack, of such compatibility and support. Such an ‘elective affinity’, and the compatibility and support found in the medical treatment for depression, is perhaps characterized by a type of hopeful resignation. These depressed people are often reluctant drug-takers and are ambivalent about the benefits of the drugs (Karp 1996, 2007), hence the ‘elective affinity’ they experience with the medical paradigm of depression can be complicated and somewhat elusive: sometimes present, sometimes not, sometimes a memory of past successes, sometimes a hope for future successes. For these people, the medical ‘story’ of depression is both helpful and unhelpful,

with benefits and disadvantages, failures and successes; and there are many areas of grey uncertainty and bright hope, tempered with much resolve and application.

In addition, there are depressed people who experience what Karp (1996: 98) calls a “deconversion” experience as a result of medical treatment for their depression, which while initially seeming therapeutic eventually disintegrates into disappointment and disillusion. These individuals find that “I had gotten so fucked up with this stuff that I will never do it again” (Karp 1996: 101) and learn that “I’d have to deal with this problem without pharmaceuticals” (Budbill 2008: 83). These people, and those who resisted medical treatment in the first place, find little or no ‘elective affinity’ with the medical profession and its paradigm of depression as an illness. For such people, medical treatment, particularly medication, seriously detracts from who they are: “Depression is a huge part of my life.... And I don’t want to lose” what skills it provides (Karp 2007: 123). Similarly, another of Karp’s (1996: 130-131) interviewees found that:

depression has made me stronger somehow ... [and] it’s made me more compassionate.... It’s something that at times I would have loved to be rid of, but I’m afraid that if [it were] excised, there’s something important about me that would be excised with it.

These views echo the sentiments of poets like Rilke, Lewis, and Budbill (Berlin 2008) who also feel that without their depression they would be diminished as people and particularly as poets. For such people, depression bestows pain *and* gifts, and rejection of, and resistance to, the former results in a concomitant loss of the latter:

You know, people say, would you like to have had a different life. I say absolutely not. I’d live it all over again. But I think it takes a while to get there. To see some of [the pain] as a real gift.... I wouldn’t give up one minute of it, not one minute of the pain. Horrible as it was, I don’t see how I could be what I am without it. (Karp 1996: 131)

As Karp (1996: 131) observes, for these people,

despite the horrors of their depression experiences, [they] would likely choose their lives over again. With all its difficulty, it is *their*

life and they see suffering as inseparable from who they are and the sensibilities they value in themselves.

This quest for authenticity is central to a many a depressed person's disavowal of the medical paradigm of depression because the experience of medical treatment, particularly drugs, led to an inauthentic life, such was the loss of the sense of self.

Equally, however, the quest for authenticity is as paramount an issue for those taking psychiatric medications as for those not (Karp 1996, 2007). Indeed, grappling with authenticity and issues of self-hood and identity are perhaps more difficult for depressed individuals who do take drugs for their depression because such drugs are, after all, designed to change the functioning of the brain. "[I]n contrast to other medications, *psychotropic drugs have as their purpose the transformation of people's moods, feelings, and perceptions*" (Karp 2007: 12). It is also possible that because pain is so shattering, forcing attention to questions of meaning as "'no other experience demands'" (Morgan 2002: 310, quoting Bakan), drug treatments for depression exacerbate this search for authentic self-hood that is already seriously highlighted in a person's life by the depression itself. This may partly explain the long, difficult, and inconclusive journeys that many depressed individuals undertake in what Karp (1996, 2007) refers to as 'careers' with medication, even a 'marriage', of sorts, to medication.

Despite its pain, however, depression can be seen as beneficial by some people. In keeping a person in touch with "an acute sense of failure", it keeps a person in touch not only with one's "real self" but also with "the depths of common humanity" in a "wholesome and honest blend of light and dark" (Budbill 2008: 90). Some who experience depression find that it is possible to "learn to limp gracefully and nobly" (Karp 1996: 125) and that depression can be protective, not only painfully devastating, because it is "like the fuse in a house with suspect wiring: it's the weakest part of the whole system, which ensures the safety of the whole" (Lewis 2008: 22). There are some who even develop a kind of ongoing 'relationship' with their depression:

I've been a free-lance writer for the past more than thirty-five years.... I have to travel quite a bit, and the Angel [of depression]



seems kind enough to let me have those trips out and not bother me. This is the agreement we've come to later in life. When I was younger she took me over whenever and wherever she wanted, with no consideration for what I had to do. In short, the quicker I can let the Angel of Depression take over my life completely and have her way with me for as long as she needs to, the sooner I can get back to my life. (Budbill 2008: 83-84)

Similarly, Lewis (2008: 22), who also calls her depression an angel, finds that while its "appearance is always unwelcome ... I have come to value its dark gifts [because] it is "more deeply in touch with reality than I am". Rilke (1966: 170, 204), also, weeps for not having initially recognized the "terrible" Angels of sadness, the "Nights / of Affliction", as "*one / of the seasons of our interior year, – not only / season – they're also place, settlement, camp, soil, dwelling*".

Where and how, in the contemporary Western framing of depression, are such people to find an 'elective affinity'? The simple answer is that, largely, they will need to look 'elsewhere'. While those who find an 'elective affinity', whether complete or sporadic, with the medical perspective on depression are legitimated in their desire to be 'well' and 'free' of depression, those who take another viewpoint find 'elective affinity' and legitimation in 'other places' such as, for example, poetry, literature, meditation, religion and spirituality, the natural world, music, painting, or depression itself. In providing 'places and spaces' for the dominant 'story' of depression (the medical 'story') *and* other 'stories' an interstitial approach to depression that I am suggesting ensures that a variety of 'stories' can be embraced and honoured as different ways of understanding, and relating to, depression. This facilitates the possibility of people discovering an 'elective affinity' that is meaningful to them. In this way, depressed people are supported and encouraged to find what is 'right' for them, something that may well evolve and change over time.

Such an inclusive approach provides possibilities for those who experience no 'elective affinity' with the medical profession, those who experience partial or intermittent 'elective affinity' with the medical profession, as well as those who are classed as having treatment-resistant depression but are still searching for an 'elective affinity' with the medical profession or *somewhere* else. Providing a greater choice does not guarantee success, but it does legitimate the existence of choices by

which individuals who experience depression might come to understand their depression, themselves, and various treatments (medical or alternative). It also ensures the freedom to choose that Weber saw characterising Western rationalism (Roth & Schluchter 1979, Kalberg 2005) but that is curtailed by the dominance of the medical ‘story’ of depression in the West. This freedom to choose may well be a journey in itself, as various possibilities are tried and different ‘stories’ are sampled.

Spirituality and religion represent sources of ‘elective affinity’ for some depressed people who discover a meaning for their depression and a way of embracing it and befriending it (Karp 1996, Caygill 2003). Many of these people view “medicine and spirituality as acting jointly” (Karp 2007: 61), underlining the viewpoint from many quarters that medicine and other approaches to depression can coexist in a beneficial way for people. One of Karp’s interviewees (Karp 1996: 127-128) found Buddhism

helped enormously. It made me feel my own life was unique. I didn’t feel that somehow it was just me. And having that stronger spiritual sense of community was really helping me see myself in a larger sense.... and helped me feel that I didn’t have to be sort of a victim.

For other individuals, literature itself (Wilson 2008: 110, 144) provides sources of ‘elective affinity’ that speaks to them about the ‘terrible beauty’ of suffering being, in Keats’ terms, the “‘vale of Soul-making’” or, in Woolf’s terms, “‘the well’ where nothing protects ... ‘from the assault of truth’ .... [and where] melancholia, dangerous though it was, [is] a source of violent truth and smoldering creation”. Keats found great affinity with and between Nature, his melancholic moods, beauty, and death, giving him a sense that he was “leading a posthumous existence” in which life and the world were beautiful and meaningful because of “suffering and death” (Wilson 2008: 105, 110). Keats advised people to “hold hard to our melancholy moods [and] urges us not to alleviate our blues with befuddling chemicals” (Wilson 2008: 111). The adoption of an interstitial approach to depression would proffer to people experiencing emotional suffering the ‘elsewhere’ places in addition to the locus of medicine for legitimisation and support.

Most encouragingly, there are illustrations that this is already beginning to happen and can be found in the many ‘inconvenient voices’ suggesting changes to medical

understandings and approaches to depression. For example, Dowrick (2004), while still employing standard medical treatments for depression when deemed necessary, provides a wonderful example of creating another way for patients to find an ‘elective affinity’ with the medical profession in the embracing of patient narrative with a focus on meaning. Dowrick (2004: 194) suggests an approach that employs narrative as a way of connecting with patients’ understandings of depression within the totality of their lives in order to help them “find some meaning and purpose out of seemingly undifferentiated suffering and distress”. Blazer (2005) also emphasizes the development of an alternative approach to depression that embraces both the values of the medical model of depression *and* a wider context, in which psychiatric approaches to mental distress are once again situated within the social realm. Even from within the dominant medical approach to depression there is recognition that factors other than efficacy of alternative depression treatments may need to be examined because of patient views (Parker & Crawford 2007).

The interstitial approach to depression that I am suggesting facilitates and fosters the exciting and inclusive ideas about emotional suffering put forward by those such as Dowrick (2004), Blazer (2005), and Wilson (2008). In promoting such different ideas about depression, and in giving voice to those suffering from depression (Karp 1996, 2007, Berlin 2008), alternative sources of ‘elective affinity’ are provided for those who find no such compatibility, or intermittent or limited compatibility, with the dominant medical model. An interstitial framing of depression would allow for the possibility of even greater inclusion of ‘other’ voices that may well provide an ‘elective affinity’ for those currently isolated and alone of any support in the form it is needed. There is perhaps no greater gift one human being can give to another than that of saying ‘I, too, walk this way. You are not alone’. And, perhaps, for those who experience emotional suffering, that by its very nature isolates and robs a person of memories, connectedness, meaning, purpose, and hope and takes him or her to seemingly endless worlds of icy, agonizing, empty darkness, such gifts are as vital as air and water.

My hope, then, of future orientations to depression being grounded in an interstitiality of respectful coexistence of difference reflects an ethical concern that *all* ‘stories’ of depression need to be honoured and valued in its overall framing so

that *all* who experience overwhelming emotional pain may find ‘somewhere’ an ‘elective affinity’ that provides compatible meaning, support, and legitimation. In this way, all are *empowered to choose* that which is supportive of, and compatible with, their individual journeys and stories of depression, regardless of how these may change. Such an approach provides one way of beginning to address what I consider to be an aching need in the modern secular West for a ‘sociodicy’<sup>5</sup> of sadness. It is also one way of “facing the fate of the times” with “integrity” as we each find and obey the dæmon “who holds the fibers” of our very lives (Weber 1991: 155-156).

Hope, however, should always be tempered by pragmatics. While I consider that future orientations to depression would be best served by an interstitial approach characterized by coexistence and respect, the reality is that the current dominance of the medical paradigm of depression is unlikely to substantially change in the near future. Nevertheless, this should not stop presentation of ideas founded on respect and coexistence that are clearly the basis for global approaches to situations where previously there was considerable intolerance and resistance to ‘other’. While there has been a radical shift in how Christianity relates to other religions, and how religions relate to each other, (see 9.3.1) there is still considerable discord resulting in not only contestation but also bloodshed and destruction. The hope stems not from solving the problems of difference but moving towards adoption of respectful dialogue and coexistence of difference. Similarly, my hope is that in the area of depression there can be a movement towards a respectful coexistence between the different ‘stories’ of depression in the same way as some are able to actively and positively accommodate the different paradigms of science and religion (see 9.3.2).

In the contemporary West, the medical paradigm of depression has clearly assumed, following Gramsci’s definition of hegemony (Fontana 1993)<sup>6</sup>, a hegemonic role, despite contestation of opinion and the existence of ‘inconvenient voices’. Although the medical view of depression is “accepted as universally valid by the general population” (Fontana 1993: 140), the liminal voices of ‘other’ are also to be discerned. Definitionally, ‘hegemony’ does not allow for the existence of ‘other’; but

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<sup>5</sup> Morgan and Wilkinson (2001: 199) refer to “sociodicy” as the secular form of what Weber termed “the problem of theodicy”; both are concerned with the place of suffering and meaning. See also Morgan 2002.

<sup>6</sup> See the footnote on page 5 of Chapter One regarding hegemony.

I am requiring this word to work harder by pushing it to the very limits of its meaning where, at its definitional edge, it can ‘see’ beyond to the existence of ‘other’. In a sense, then, I am creating a ‘neo-hegemony’ in that, through an interstitiality of respectful dialogue and coexistence of difference, I am attempting to give ‘hegemony’ some ‘eyes’. Perhaps respectful acknowledgement, as opposed to disrespectful denial, characterizes the difference between ‘hegemony’ and ‘neo-hegemony’. A “polyphonic relatedness” (Ratzinger & Habermas 2006: 79) between difference then becomes possible, rather than division and the domination of one viewpoint over others. In this way, not only can the various perspectives on depression come together but those that are liminal at present can also have a place and a space in this interstitiality because emphasis is on the respectful coexistence of difference not on domination and / or rejection of ‘other’ by the dominant ‘one’. As disruptive and uncomfortable as the ‘other’ can be, “[r]adical difference cannot be eliminated.... [and we] should defend differences and plurality” (Tracy 1987: 52, 65).

Some ‘inconvenient voices’ are particularly valuable as they are not merely ‘other’ voices in themselves, offering alternative viewpoints on depression, but actively stand against the ‘othering’ of depression itself. “What would it mean”, to paraphrase Levinas (Davis 1996: 144) again, if we responded to depression not with the violence of resistance but with acceptance, and not by suppressing it but by listening to it? Indeed, what might depression say to us if we allowed it voice, instead of ‘drugging’ it into oblivion or ‘talking’ it into exile? Furthermore, what might those who have listened to this face of Other have to tell us about what it says and about their experiences of it? Unfortunately, those who do tell such different ‘stories’ are often not welcome and find, “like most returning heroes”, that other people do not want to be told stories about “woundedness” because they do not want to be reminded “of their own wounds” (Frank 1997: 184-185).

Yet, extending Frank’s (1997: 185) description about those who “know they are wounded”, for those who recognize they are similarly ‘touched’ by depression in some way, stories that speak of listening, instead of suppressing, and accepting, instead of resisting, are welcome. Moreover, while sitting uneasily in the modern ethos of health and happiness, the recognition of the close relationship between suffering and meaning in a person’s life evident in Western literature is valued by

those who have journeyed into depression. Such a relationship is explored in literature extending from the story of Job to the ancient Greek tragic poets and Aristotle to Frankl's (2004) insistence that within suffering can be found meaning. These 'stories' are important in pointing to alternative conceptions of suffering in which acceptance is a vital element. The acceptance of personal woundedness and the idea that suffering is part of the human condition can form the basis of poetry (Rilke 1966), of spiritual vocation (Nouwen 1979), of reflections on the human condition (Moore 2004), and of the call for a 'sociodicy' of suffering (Morgan & Wilkinson 2001).

However, acceptance of 'other' (depression itself) and 'other' approaches to depression need to be subjected to continuous analysis and evaluation because sometimes pseudo or partial acceptance can convincingly masquerade as acceptance. While an interstitiality of respectful coexistence of approaches to depression prevents this situation arising, the present dominance of the medical paradigm is likely to metamorphose such inclusivity into an inclusivity premised on certain criteria. This arises from two interrelated factors. One is the need by 'other' to be accepted, and the other is the need by the dominant paradigm to maintain its power of control. For example, CAM, in asserting its own forms of healing, both resists medicine and at the same time also seeks acceptance by it (Goldner 2004). In seeking such legitimation, however, some opinion considers that CAM ceases to be alternative because it has had to change in order to be accepted (Villanueva-Russell 2005, Barry 2006). If acceptance of alternative views of depression is dependent on them meeting certain medically determined criteria then such acceptance is both limited and compromised and only constitutes an artificial or restricted acceptance.

This problem can also be seen in the area of disability where there is concern that acceptance of disability begins from a position of 'abnormality' and therefore does not constitute acceptance of disability. Disability research, both medical and sociological, is "rebuked [for] taking the individual experience of abnormality as their starting point" (Williams 1999: 244). Research that focuses on the individual narrative of disability can inadvertently result in situating the person as "victim" of their disability (Mulvany 2000: 594) rather than situating disability as being part of their personal identity. Acceptance of depression only to resist and control it or to see

a depressed person as a victim of mental illness represent certain ‘stories’ of depression. This type of acceptance, however, does not embody acceptance of depression as ‘other’. Such acceptance of ‘other’, as with acceptance of CAM, hardly, in the final analysis, constitutes much of an acceptance at all. In these examples, I suggest, can be seen the difficulty that the West has in accommodating the ‘other’: difference is accepted so long as it is controlled and regulated in some way or prevented, struggled against or risen above. Such restricted acceptance of ‘other’ does not represent the interstitiality of difference that I envisage. Conversely, because interstitial respect and coexistence is reciprocal, the ‘other’ that does not respect the dominant medical paradigm, demanding or expecting changes to align medicine with their alternative position on depression, is as guilty of exclusivity and non-acceptance of what it perceives as ‘other’ as medicine so often is.

Foundational to the medical approach to depression in the future is an emphasis on the belief that more medical research will provide greater understanding of depression and the creation of better treatments. While this will certainly be valuable, as will sociological research examining the social aspects of depression, I consider that these are only some of the ‘stories’ about depression. There are other ‘stories’, revealed by many of the ‘inconvenient voices’, which also need a place and a space. The latter ‘stories’, particularly the more ‘alien’ of these, may well, given the contemporary Western framing of depression (largely determined by the medical paradigm of depression), only reside “‘at the edges’” (Kalberg 1980: 1176). Consequently, they may only be expressed in voluntary groups (Kalberg 1980, Seidman 1984) and small close-knit gatherings that Weber (1991) saw characterizing the liminal position of the values inherent in ethical substantive rationality in secular modernity. However, as “Margaret Mead famously said, ‘Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has’” (Wallis 2008: 53).

Such sentiments are not without basis as the growth of support groups for various illnesses and conditions and consumer and social health movements, despite problems, have been found to influence health professionals and health policy (Brown & Zavestoski 2004, Hess 2004, Allsop *et al.* 2006). Paradoxically, it is the belief in egalitarianism and equal rights stemming from Enlightenment and classical

liberalism, that promoted a rationalist total world-view and caused the “disenchantment of the world” (Weber 1991: 155), that has fuelled what eventually became social movements ranging from the abolition of slavery to women’s rights to gay rights (Kalberg 1980) to ‘shy pride’ (S. Scott 2006).

Moreover, encouragingly, there is also some acknowledgment in the medical field of the need to “be conscious that it is not the strong who should determine how we define and treat depression” (Cole 2007). Additionally, there is recognition that the ‘constituencies’ of depression (Horwitz & Wakefield 2005, 2007) need to be significantly broadened to include, on an equal basis, not only the current players (such as health professionals, pharmaceutical companies, government agencies, health care providers, and research institutions) but also those experiencing depression and their families. However, I do not consider that the presence of ‘inconvenient voices’ can immediately and radically change the medical dominance of the contemporary Western framing of depression. But, I am hopeful that their growing existence, particularly within medicine itself (Dewhurst 2004, Dowrick 2004, Blazer 2005, Summerfield 2006a), portends well for enriching developments in future approaches to depression and may even eventually inaugurate the interstitiality of respectful coexistence of different perspectives that I am suggesting.

## 9.5 Conclusion

In this chapter, I have considered how approaches in other areas may provide useful material on how to negotiate the difficulties that predictably arise when different perspectives meet, particularly between a dominant point of view and ‘other’ points of view. In applying the fifth and final part of my Quatrefoil Model to the subject of depression I have presented ideas whereby in the future the different ‘stories’ of depression may be heard with respect, where they may coexist, and where, in their meeting, creative possibilities, as yet unknown, may eventuate. The overarching unity afforded by substantive ethical rationality, previously facilitated by religion in the West, is no longer possible; but while this has led to “disenchantment” (Weber 1991: 155) it has also led to greater personal freedom to choose (Roth & Schluchter



1979). In addition, I would also add that it now heralds a new possibility of coexistence and respect in an interstitiality where difference and inevitable disagreement can meet and coexist and respectful dialogue can eventuate. This freedom to choose, in combination with an interstitial approach to depression based on coexistence and respect, facilitates inclusion of a wider perspective on depression that can become inclusively representative of the rich diversity of approaches to suffering that have characterized the West's journey with suffering over the last four millennia (see Chapter Three).

While the future orientations to depression are inevitably and strongly influenced by the historical, interpretative, meaning, and public orientations discussed in the preceding four chapters, the form of the future orientations is not pre-determined by these other orientations. Indeed, the presence of 'inconvenient voices' and divergent points of view consistently provide other possibilities, and thereby contribute to and foster the evolving nature of future orientations and reinforce the need for an interstitiality of respectful coexistence. Nevertheless, I also recognize that such future orientations to depression as I am suggesting largely run counter to the direction that the majority of approaches to depression are currently taking. If it appears to others that such an interstitiality of respectful inclusivity and coexistence as I am proposing is not possible, it may be (following Grant *et al.* 2004: 281) that "their theories have not yet allowed it". My voice, then, belongs to those who, at present, occupy a liminal position in their approaches to depression.

The meeting of difference, however, is an ongoing conversation leading to no definitive conclusion, but engaging and creating possibilities because of difference:

Conversation ... is an exploration of possibilities in the search for truth. In following the track of any question, we must allow for difference and otherness. At the same time, as the question takes over, we notice that to attend to the other as other, the different as different, is also to understand the different as possible. To recognize possibility is to sense some similarity to what we have already experienced or understood. But similarity here must be described as similarity-in-difference.... (Tracy 1987: 20)

Recognition of the 'other' as possible leads to paradox. It is dealing with this paradox that underlies foundational issues concerned with various perspectives on

depression; and it is an approach to depression based on an interstitiality characterized by coexistence and respect that facilitates places and spaces for the paradox arising from this variety of different approaches to depression. That depression could be both demon and dæmon<sup>7</sup> is a paradox as difficult for many a depressed person to deal with as for those in the field of depression research to accommodate in their studies. Yet, in the interstitial zone between the dominant framing of depression and other framings, however liminal, lies the possibility of exploring such paradox and of living productively and ethically with it.

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<sup>7</sup> See the footnote on page 30 of Chapter One for clarification of my use of ‘demon’ and ‘dæmon’.

## Chapter Ten – Conclusion

# The Paradox of Depression: Demon and Dæmon

**[W]e live in the belly of paradox.**

(David Ranson)<sup>1</sup>

**[A]s we know there are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns – the ones we don't know we don't know. And ... it is the latter category that tends to be the difficult one.**

(Donald Rumsfeld)<sup>2</sup>

**Negative Capability, that is when man is capable of being in uncertainties, Mysteries, doubts.**

(John Keats)<sup>3</sup>

### 10.1 Introduction

Depression is a subject about which a plethora of ‘stories’ is to be discovered. This doctoral thesis, exploring the framing of depression in contemporary Western culture, is *my* ‘story’ of depression: it is a search, at the nexus of academic research and personal journey, which endeavours to understand *why* we think what we think about depression. In providing an alternative approach to depression to those currently available it constitutes my contribution to extending efforts in, and answering calls to ‘re-think’, both depression and sociological research (Karp 1996, 2001, 2007, Busfield 2001, Dowrick 2004, Blazer 2005, Horwitz & Wakefield 2007, Nettleton 2007, Pilgrim 2007). It is but one ‘story’ among many and, in adding my

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<sup>1</sup> Ranson 2009: 13

<sup>2</sup> Rumsfeld 2002: 8

<sup>3</sup> Wood 2005: 7

voice to other voices, I consider that I have added something worthwhile to the field of depression research. Ever the astute observer of life, Coleridge (1864: 68) aptly describes a single thought, like a wave, as taking “form and shape” from those around it. Likewise, I consider that my research is also formed and shaped by other research. Although my own work, this thesis, nevertheless, builds on and draws from the valuable, fascinating, insightful, and sometimes moving research undertaken by the many sociologists, medical professionals, theorists, scholars, and writers that I refer to in this thesis. Without their research efforts, my study would not have been possible; I am sincerely indebted to them all.

During the course of researching and writing this thesis, the practice of self-critiquing instilled in me a clear sense that my efforts represent the development of ideas about depression in one direction only. Consequently, I recognize that my study will not be to everyone’s liking or interest, and therein lies the great value of plurality of perspective. Different viewpoints add different elements to the ‘story’ of depression, which is all the richer for such diversity. My research is undergirded by two interconnected ethical concerns: one is respect both for the dominant voices and for the ‘other’ voices, and the second is an ethical concern for hope. This is both a hope to discover a viably alternative way of looking at depression and a hope that such an endeavour facilitates respectful coexistence of differing ideas about depression. Together, these two ethical concerns coalesce into the hope that future orientations to depression are characterized by inclusivity and dialogue: an interstitiality of the coexistence of difference and respect for difference. My research furnishes an original perspective on depression through its use of a five-part theoretical model that reveals the framing of depression to be culturally and historically situated.

## **10.2 Stories of Depression**

This thesis is the endpoint of a long and convoluted journey exploring depression. After pursuing various options, I finally discovered that a combination of concepts drawn from Weber, Derrida, and Levinas provided the richest and most pertinent

material from which to construct a theoretical model. Through its application to depression literature, largely drawn from the academic fields of medicine and sociology, I explored how depression in the contemporary secular West is framed. The five orientations of my theoretical model furnish views on five different, but interrelated, aspects of depression that together comprise one way of exploring and understanding depression.

The four orientations constituting the ‘leaves’ of the Quatrefoil Model reflect polarities from the Motifs of Suffering in Western culture (‘acceptance / resistance’, ‘relationship / causality’, ‘chaos / certainty’, and ‘descent / ascent’), which I discerned from a brief examination of the Western response to suffering. My study demonstrates that the Western framing of depression is strongly characterized by certainty of point of view about depression, resistance to depression through problem-solving, emphasis on causality of depression, and ascent from depression. Nevertheless, such framing, while hegemonic, is not so dominant as to completely prevent or inhibit other viewpoints, something clearly demonstrated by the presence of diverse opinion and ‘inconvenient voices’. Indeed, it is the very contestation and variety of ideas about depression that, in my opinion, require an interstitiality in which difference can coexist and in which ‘other’ can remain ‘other’ and still be included. As with so much in the world today, the ‘story’ of depression is but one ‘story’ that compels us all, I believe, to write the next chapter under the heading of ‘respectful dialogue and coexistence of difference’.

Perhaps one of the most frustrating aspects of this study has been the worthwhile areas of exploration I have had to forsake or restrict in delimiting my scope to a manageable size, but that, nevertheless, point to a considerable number of possible directions for future research. For example, Weber’s concept of the Protestant ethic is deserving of more in-depth application to the contemporary framing of depression. The meanings assigned to depression would also benefit from a far wider exploration, as would the impact of social health movements and public perceptions of depression. In particular, an in-depth examination of ideas about depression evident in the personal experiences and responses to depression (stories, poetry, art) from members of the public shared on websites such as *beyondblue* and the *Black Dog Institute* would be both a fascinating and worthwhile area for future research.

Additionally, research similar to that conducted for Chapter Eight on *beyondblue* that extends analysis of, including comparisons between, not only other Australian websites on depression but also those from other countries, such as the United Kingdom, Canada, New Zealand, and the United States, would be a fruitful and interesting exercise. Another important area for further research is the religion / science divide and its impact on the relationship between spirituality and depression.

There is also a bountiful range of other ideas to be drawn from Weber, Derrida, and Levinas, as well as from others such as Habermas or Deleuze that would all support fascinating and instructive applications to depression. In particular, the possibilities presented by, for example, Weber's concepts of *wertrational* and *zweckrational* (which I barely mention) or Derrida's concept of hospitality (which I mention in passing) warrant further investigation in terms of approaches to understanding the contemporary framing of depression. Another interesting direction to pursue by which to further explore sadness / depression would be an examination of poetry / literature across the millennia in terms of meaning and Weber's concept of 'elective affinity'. In addition, the exploration of whether, in what ways, and by how much Western society is causing depression is another field of research worthy of more work.

One area of future research that I find quite compelling and which would extend my interest in developing and legitimating 'a place and a space for tears' is to, following Morgan and Wilkinson (2001) and Morgan (2002), construct a comprehensive 'sociodicy of sadness'. Such a sociodicy would provide a way of journeying *with* sadness, and facilitate both attempts to rationalize and reconcile the existence of sadness as well as to allow for the exploration of relationship with sadness and its constituent place as part of the human experience of life and living. I see such a sociodicy as grounded in an ethical respect for and concern with the tensions implicit in sadness itself, in attempts to understand sadness, and between the various perspectives on sadness.

Another potentially fascinating area of future research would be to extend my examination of Western literature in terms of the Motifs of Suffering and to also devise a complementary Motifs of Happiness. The examination of these two sets of

motifs as they are reflected in literature would be a fruitful way of studying the West's relationship with suffering and happiness, the connection between them, and how the various motifs oscillate, intertwine or resist each other. In addition, I would particularly like to examine contemporary poetry, or perhaps poetry over the last hundred years or so, to ascertain engagement with or resistance against depression and sadness or suffering generally.

On the whole, particularly given the size constraint of a doctoral thesis and the complexity and span of ideas and topics I broach, this study succeeds, even if only in an introductory way, in its aim of facilitating an alternative outlook on depression that both values and critiques the current framing and in its suggestion that inclusivity be the hall-mark of future approaches to depression. If dialogue is accepted as “the mode of human life and a manifestation of the dialogical reality of all human life” (Tracy 1987: 28) then an emphasis on dialogic coexistence is preferable to dialectical synthesis or rejection. In defending difference and the plurality of difference (Tracy 1987), we need dialogue, between those holding disparate opinions and even with depression itself, not to arrive at an authoritative conclusion and certainty but to engage in a process revealing and affirming different possibilities.

Nettleton (2007: 2409) writes about the need in sociological research for “*transferable* conceptual tools and theorisations” that are more than “*just* a ‘problem solving’ orientation”. I think that the theoretical model I develop for exploring depression constitutes just such a “*transferable*” conceptual tool and theory. While my focus has been specifically on depression in this thesis, the Quatrefoil Model of Historical-Cultural Framing, is, I suggest a theoretical model that can be utilized in other sociological research because it facilitates an approach concerned with explicating *why* we think what we think about a particular topic. Through its five orientations, it directs attention to the drivers behind the subject of research, their impact and influence, and the implications for future directions. For example, I can see uses for this theoretical model in examining fundamentalism in contemporary Western culture, whether of religious, political, commercial, or scientific origins, and in exploring the relationship between humans and the environment in a variety of cultural settings. I also think that it would be fascinating to apply my theoretical

model to non-Western cultures. In India, where there is a pronounced historical-religious tendency to absorb other gods into an ever-growing pantheon, the absence of a total world-view as it exists in the West would provide some intriguing research possibilities, utilizing my Quatrefoil Model, of cross-cultural studies in comparison with the West. Such research might also usefully lead to adaptation or redesign of this theoretical model that better accommodates and facilitates the study of various cultures of non-occidental origin.

Research on “the minutiae of social life ... always need to be understood in relation to broader debates about the current state and changing nature of the contemporary world” (Nettleton 2007: 2410). My theoretical model facilitates research providing a meta-perspective, and thus falls into Nettleton’s category of “broader debates”. The opportunity of utilizing “an historically-informed sociological imagination” in application to “some of the major concerns of contemporary societies” is not only restricted by epidemiological concerns (Williams 2003: 149), interest in the ‘minutiae’, or emphasis on quantitative research, but also by the very theoretical ‘lens’ used to carry out such studies. While constrained by the fact that it too is a lens through which I have looked to carry out this study, my theoretical model, nevertheless, enables an approach that is particularly alert to this problematic. It is for this reason that it has been able to offer some insights into Pilgrim’s (2007) question about why psychiatric diagnosis has survived; this is achieved not through analysis of the detail of diagnostic issues but through investigation of the historical-cultural framing of depression in which such diagnostic survival is both result and symptom of wider framing issues.

My research for this thesis has given me a strong sense that there exists a multiplicity of fascinating and insightful ‘stories’ about depression, with each one contributing something of value to our understanding of depression. However, I am concerned about the often scathing disagreements between, and attitudes of, proponents of differing viewpoints and about the dismissal and disregard of many of the ‘inconvenient voices’ that sometimes provide quite radical perspectives. Not that such contestation exists, because vigorous debate can be positive and productive, but that it is fuelled by Western rationalism and a total world-view perspective in the search for the one ‘truth’. Such a perspective is antithetical to cooperative dialogue.



This search for the one ‘truth’ has, arguably, long plagued Western culture. Over many centuries on many subjects many have proclaimed, as the Russian poet Marina Tsvetayeva succinctly observes (Bowen *et al.* 2005: 278), “I know the truth – give up all other truths!” However, such proclamations, and the intent behind them, are not conducive to a multiplicity of voices and inevitably marginalize other truths, curtail other ‘stories’, and thwart and stifle open dialogue between the different voices.

The complexity and inherent pain of depression, and suffering generally, are such that maybe any rationally constructed theoretical framework cannot adequately capture their meaning or essence or enable a comprehensive analysis and understanding. Nevertheless, theoretical models like the Quatrefoil Model of Historical-Cultural Framing and the Motifs of Suffering are valuable as means, however inadequate and limited, of approaching subjects such as depression and suffering. Indeed, their value is in facilitating exploration, not in providing conclusive and definitive findings. Moreover, though consisting of separate categories, as is characteristic of any theoretical framework, these categories are merely ‘tools of approach’, not discrete entities that cannot be adapted or changed. Recognizing the partial and transient nature of these rationalist frameworks, and of the resulting research, is vital to understanding their value:

The ‘truths’ and empirical findings of sociological research are always the result or product of particular frameworks and methodologies. These partial results are always temporary and contingent. (Turner 1996: xiv)

Although pain is perhaps always beyond rationalist understanding, rationalist thought, nevertheless, can furnish ‘ways of knowing’ about pain through theoretical models such as devised for this study. A particular strength of the Quatrefoil Model is its encouragement of the respectful coexistence of different stories of depression and its promotion of dialogic engagement between the various voices that produce these different stories. In this way, for example, the medical-scientific stories of depression as illness, that emphasize fact and evidence and the control of depression, can coexist with poetic stories of depression as gift, that emphasize acceptance and honour and the embrace of depression. Similarly, the Motifs of Suffering, in

exploring various Western responses to suffering, facilitate recognition of difference and do not privilege some responses as superior to others, but incorporate and sustain differences and the tensions between them.

These different depression ‘stories’ offer different ‘truths’. While individual and separate, they constitute an ongoing, interrelated conversation about depression, in which each participant and their ideas could benefit from an emphasis on respectful dialogue. Milton’s twin poems *L’Allegro* and *Il Penseroso* are joined in a “kind of *involution*”, an inseparable “solitary companionship” of dissonance and harmony (Finch & Brown 1990: 18, 20) that is concerned with what is both “loathed” and “holy” (Milton 2007: 15-24). So also, I think, are the various stories concerned with depression, and in the interstitiality of the harmonious coexistence of difference an enriching interplay between these different perspectives can take place, even though, together, they may be antithetical and, hence, paradoxical.

### 10.3 Paradox

Depression elicits opinions and approaches that are paradoxical: depression is an illness requiring medical intervention and treatment to achieve recovery; but, depression is also a ‘terrible angel’ that is the ground of being. Such paradox is uncomfortable. That depression could be both demon and dæmon requires dwelling within paradox and not attempting to unravel these contradictions. Yet, in contemporary secular Western culture paradox is resisted, if not reviled:

In our own Hellenist-inspired penchant for clarity and all things linear, we find it difficult to enter into paradox and celebrate its potential. We instinctively try and do away with contradictions in our desire that things be one-sided and clear. With this mindset, the experience of paradox becomes regarded as a temporary annoyance to be eliminated as quickly as possible. If only we could make things straightforward. (Ranson 2009: 7-8)

The paradox arising from the variety of approaches to depression (which are often antithetical), and even from depression itself, makes for confusion and divisiveness,

but also for plurality and possibility. This, I suggest, is the “unnameable infant” Derrida saw arising from the two interpretative positions (Derrida’s 1978: 293). Living with paradox requires a “negative capability”:

the capacity to endure uncertainty, to live with ambiguity, to keep alive questions to which one does not know the answers.... Negative capability is clearly not in itself negative, but a capacity, or disposition, to accommodate the negative. It is consonant with the recognition that there are times when the quest for certainty is pathological. (Wood 2005: 194)

It is this living with uncertainty and the impossibility of definitive interpretation and meaning that is so hard. The Motifs of Suffering are testimony to a long-standing journey in the West of coping with the paradox of suffering. This journey is not over, but is arguably much harder now than at any point in history because of the combination of the dominance of Western rationalism and the pervasive ethos of happiness. This study has revealed a particularly pronounced focus on depression as something to be understood, named, and controlled. Yet, there are signs that such a restricted framing of depression is already evolving, and my study represents another contribution to encouraging and facilitating this evolution.

That depression might be a paradox, something that is apparently contradictory or absurd yet might be true, and that it might remain a paradox without an answer is anathema to secular Western modernity’s emphasis on rationalist science, as is the paradox of valuing antithetical views about depression. Nevertheless, even science, particularly quantum physics, is revealing itself paradoxical in ways not previously thought possible, even by scientists (Campbell 2008, Coffey 2008b). The contemporary Western rationalist insistence on certainty and control is buffeted by uncertainty and paradox and also by the problems of “the ‘disenchantment of the world’” (Weber 1991: 155) caused by this rationality. This presents to the modern secular West a paradox “of management but also of meaning” (Roth & Schluchter 1979: 13).

Moreover, paradox is something that, given considerable advances in the Western quality of life and the associated transition from want of materials to live to want of meaning to live, is arguably of increasing concern and interest (Easterbrook 2004). In

its provision of more freedoms, individualization, and greater affluence the paradoxical nature of modern Western life is revealing itself in greater pathologies and less freedom (Honneth 2004, Hamilton 2008) and a “puzzling diversity of options and possibilities” (Williams & Bendelow 1998: 68, referring to Giddens). We need to both acknowledge that “unhappiness persists and is wholly real” and that we “live in a favored age yet do not feel favored”, and then try to answer the question about what this “paradox tells us about ourselves and our future” (Easterbrook 2004: xix-xx).

Interstitiality, governed by the coexistence of difference and the mutual respect for difference, is, I suggest, one way of dwelling within “the belly of paradox” (Ranson: 2009: 13) and living with its confusions and implausibilities as well being enriched by its possibilities. Respect for plurality of views about depression, in addition to accepting, even embracing, the presence of paradox, requires a “‘negative capability’” (Wood 2005: 194). Depression is both demon and dæmon, both devil and angel, touching humans in ways both demonic and angelic; thus, can but be a paradox. Yet paradox is vital: “‘We utter paradoxes not to mystify or avoid problems, but precisely to stop ourselves making things easy ... because we have to speak in a way that keeps a question alive’” (Rayment-Pickard 2007: 23, quoting Williams). This task of questioning is, of course, the essential characteristic defining the ‘inconvenient voices’; but in such an interstitiality as I am proposing, where paradox is embraced, these ‘inconvenient voices’ undergo a name change. They become, quite simply, ‘voices’: voices among other voices, because difference is applauded, affirmed, and valorized.

## 10.4 Conclusion

Perhaps absurdly, for a study on the sombre subject of depression, I have decided to conclude this thesis on a note of humour as well as paradox. To paraphrase and extend Rumsfeld’s (2002: 8) now famous (infamous!) words<sup>4</sup>, that are both amusing and profoundly philosophical: there are some things we know about depression

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<sup>4</sup> See the full quotation on page 289 at the beginning of this chapter.

(these are the “known knowns”); there are other things that we know that as yet we do not know about depression (these are the “known unknowns”); finally, there are also the things about depression that we do not know that we do not know (these are the “unknown unknowns”). In addition, even what is known about depression is often contested, reflecting different points of view. The result is thus complex and divisive, uncertain and confusing, inconclusive and incomplete: it is a paradox that leads to different ‘stories’, encourages different journeys, and all have value and provide insight. There is much that has been learnt about depression from both medicine and sociology, as well as from other disciplines; there is undoubtedly still much to learn; additionally, there will probably be further developments in the future of which presently we have no inkling. In allowing for all these possibilities, the known and the unknown, the framing of depression in the future could be substantially enriched over the current framing by transforming its exclusive boundaries into an interstitiality of coexistence and respect for difference.

The portrait of the human is rendered in *chiaroscuro*: not only *chiaro* (light), but also *oscuro* (dark). The emphasis in the contemporary West on the pursuit of happiness (Williams 2000b, Garrett 2005, Rutledge 2006, Mitchell 2008a) is facilitated by the availability of a plethora of advice about how to achieve happiness (Dowrick 2005, Kohn 2006b) as well as health and success. When combined with less toleration of emotional pain (Shaw & Woodward 2004b) this reveals, I suggest, a portrait devoid of shade and shadow. The approach to depression as an illness to be correctly treated is but one example of this current ‘painterly’ tendency. The dark shades and shadows comprising what it means to be a feeling human being are effectively painted over in light tints and bright hues, thereby reducing depth and tonal variation in the human portrait. While historically the West has shown a continuum of responses to suffering there is now largely a pursuit of ‘light’ over ‘dark’. But, as Woland asks in Bulgakov’s satirical fantasy (1989: 368), “‘what would the earth look like if shadows disappeared from it? Would you like to denude the earth of ... all living things in order to satisfy your fantasy of rejoicing in the light?’”. Humans are creatures of both light and dark, both brightness and shadow, both hope and despair, both joy and suffering, both happiness and depression. As paradoxical as this is, as difficult as this is at times to live with, I suggest an approach to emotions in the future that allows for many ‘stories’ is far better than one that only allows for one sort of ‘story’ that

privileges happiness over depression, marginalizing the latter to a liminal existence ‘at the edges’.

It is learning to live with plurality and paradox that I consider to be the underlying issues of depression in the contemporary West. Negotiating through the various ‘knowns’ about depression, that are often in disagreement, determining the ‘known unknowns’ about depression, and remaining mindful that there may be things we simply do not know that we do not know is a difficult journey. While we need some certainties in life, because humans need the reassurance of centred interpretations (Derrida 1978), we also need to acknowledge the presence of, and live with, paradox and uncertainty within the disorder of plurality.

Weber seems to have understood this as he chose, “‘religiously unmusical’” (Turner 1996b: 46) as he was, to finish his lecture on science (Weber 1999: 129-156) with a quote from Isaiah 21:11 about the Watchman of Se’ir: “The morning cometh, and also the night: if ye will enquire, enquire ye: return, come” is the Watchman’s reply to a question about the night and morning. I think Weber recognized that we need to live with both ‘night’ and ‘morning’: with the certainty that comes with light and with the uncertainty that comes with darkness. Within the certainty and control of Western rationalism and within the chaos of suffering of a “disenchanted” world, we are to proceed through life with “integrity” (Weber 1991: 148, 156). Our enquiries are called for and vindicated, but we will always have to return, coming back again and again with our questions. In the future, we will have ‘morning’ (more knowledge and understanding, certainty and control) but also ‘night’ (more uncertainty, paradox, silence), and we will ask more questions because it is in the nature of humans to ask questions. Both answers (night and morning) are valuable and necessary, but they tell different ‘stories’ because that is the nature of human life. And we need both: a place and a space for joy and, even if it is currently only ‘at the edges’, also ‘a place and a space for tears’.

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# Appendix A

## Quatrefoil

The use of the quatrefoil as a name for, and a visual representation of, my theoretical model arose from doodling exercises in which I strove to diagrammatically ascertain and delineate what I was doing, how I was going to do it, how the parts would relate to each other and to the whole, and to find something that visually represented all of these endeavours. At one point, I realized that the circles I had been drawing representing the various areas of discussion (that later became chapters Five to Nine) looked remarkably like a quatrefoil. I then realized that the quatrefoil not only represented the theoretical structure of my thesis in both form and content but also, in addition, strongly related to the intent and ‘flavour’ of my thesis as a whole.

The quatrefoil is an ancient symbol in Western culture. It is a Celtic symbol that represents the ‘wheel of being’, with each of the four circles signifying one of the four elements (or seasons or directions) and the fifth central circle, formed by the intersecting of these four circles, signifying balance. In Christianity, the quatrefoil is a symbol of the cross, of the relationship between the Trinity and the individual, and also of the four evangelists. It has also long been used in architecture, heraldry and ornamentation, and as a symbol of good luck or good tidings. In the West, then, it has a long history of both pagan and Christian associations and uses. Secondly, the quatrefoil is an organic structure found in nature, where, particularly in the Cruciferae family, it can be seen in four-leafed or four-petalled plants. Finally, the quatrefoil shape itself suggests balance, softness, and openness.

In choosing to name my theoretical framework the ‘Quatrefoil Model of Historical-Cultural Framing’ I have intentionally selected it because it is a symbol long used in Western culture signifying relationship and balance, it is a natural structure representing organic growth, and it is a geometric shape characterizing symmetry and harmony. My theoretical model, and my whole thesis, is not a sharp and hard-edged knife designed to cut through things, but a rounded and soft lens inviting

another way of looking at the world; it is not a pointed arrow designed to pierce, but a curved crucible holding creative possibilities; it is not a static marbled edifice, but an organic entity holding the potential for growth, development, and even change.

Structurally the quatrefoil represents the form and content of the main discussions in my thesis: four motifs of suffering and four orientations to depression, with the fifth orientation created by the intersection of these four. Although clearly rationalist constructions, their purpose is not to compartmentalize discussion and research but to foster exploration, respectful dialogue, and the coexistence and recognition of the existence of difference. Thematically, the quatrefoil represents the purpose of my theory and thesis overall: an approach that is essentially one of gently suggesting an alternative perspective rooted in an historical-cultural framing and that facilitates difference and encourages respectful dialogue. Indeed, the Celtic concept of the fifth central circle being one of balance, uniting the four elements in a dynamic balance, beautifully illustrates my intent of bringing together divergence into an interstitiality of creative possibilities for the future framing of depression in Western culture.

# Appendix B

## Abbreviations

<b>ABC</b>	<i>Australian Broadcasting Corporation</i>
<b>AHB</b>	<i>The Australian Hymn Book</i> (book)
<b>BCE</b>	before the Common Era
<b>BMJ</b>	<i>British Medical Journal</i>
<b>CAM</b>	Complementary and alternative medicine
<b>CBT</b>	Cognitive behavioural therapy
<b>CD</b>	Compact disc
<b>DSM-IV</b>	<i>Diagnostic and Statistical Manual of Mental Disorders IV</i> (there are earlier versions)
<b>DVD</b>	Digital videodisc
<b>EBM</b>	Evidence-based medicine
<b>ECT</b>	Electroconvulsive therapy
<b>ICD-10</b>	<i>International Classification of Disease 10</i> (there are earlier versions)
<b>JAMA</b>	<i>Journal of the American Medical Association</i>
<b>MJA</b>	<i>The Medical Journal of Australia</i>
<b>NEJM</b>	<i>The New England Journal of Medicine</i>
<b>NRSV</b>	<i>The New Revised Standard Version</i> (of the Christian Bible)
<b>RCT</b>	Randomized clinical trial
<b>SSRI</b>	Selective serotonin reuptake inhibitor
<b>TIS</b>	<i>Together In Song</i> (book)