

Depression and Stigma in American Culture

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*There is nothing I can do
against your coming.*

-- Jane Kenyon, "Having It out with Melancholy"

The emerging field of health studies makes an important distinction between “disease” and “illness.” *Disease* signifies the source and nature of the body’s distress, as when we refer to the abnormal cell divisions and growth that cause cancer, or to the physical symptoms that characterize cancer’s impact on the body (such as fatigue, pain, dizziness). *Illness* refers to meanings attributed to disease in culture, meanings which are socially constructed and so change over time and vary among different cultures. In this essay, I will explore the importance of the social meanings attributed to illness in the United States, focusing in particular on depression. Given the prevalence of depression in contemporary American culture, an important question is why is the illness stigmatized? Why do people feel ashamed of having this illness, perhaps hiding their suffering from friends and coworkers? My goal here is to use cultural attitudes toward depression as a case study to encourage students of health studies to explore the cultural meanings attached to different diseases and to consider the ways in which such socially-constructed narratives affect the perspectives of medical institutions, health care providers, and patients.

Disease and Illness

In her groundbreaking book, *Illness as Metaphor*, Susan Sontag defined the world of the body’s suffering as both the landscape of biological disease and a socially constructed system of representation. Together, she argued, biology and culture created another culture, “the kingdom of the ill,” a country one could enter at any time, perhaps never again receiving the return passport for the “kingdom of the well” (Sontag, 1989, p. 3). Sontag’s book was a philosophical meditation on the cultural meanings ascribed to tuberculosis and cancer (and, in a second edition, AIDS). These two diseases “have been spectacularly, and similarly, encumbered by the

trappings of metaphor” (Sontag, 1989, p. 5). The “popular mythology” of tuberculosis in the late nineteenth and early twentieth century turned this disease of the lungs into an illness associated with heightened sensitivity, artistic yearnings, and physical delicacy (Sontag, 1989, p. 6). Originally tuberculosis seemed an aristocratic ailment, but as the flow of immigrants increased, many of them contracting the disease because of poor sanitation and housing, it began to change meanings and become linked with metaphors of dirt and pollution.

Focusing on the meanings given to cancer during the mid and late twentieth century, Sontag explores the metaphors of invasion and abnormality that made cancer a frightening – even unspeakable – disease. According to the American cultural narratives Sontag analyzes, cancer attacks the body; the disease is imagined as foreign enemy that makes the body polluted and alien. Consequently metaphors of war and military exploit are used to describe the roles of patient and doctor. The patient is expected to “fight” cancer and to “win the battle” against the disease, while doctors and researchers set out to “conquer” cancer. “Ostensibly, the illness is the culprit,” Sontag observes. “But it is also the cancer patient who is made culpable. . . . Conventions of treating cancer as no mere disease but as a demonic enemy make cancer not just a lethal disease but a shameful one” (Sontag, 1989, p. 57).

In *At the Will of the Body*, his memoir reflecting on his experiences with cancer and heart disease, sociologist Arthur Frank gives a useful definition of the difference between “disease” and “illness” that is helpful for anyone doing work in health and illness studies. Disease is the supposedly “objective” phenomenon of the malfunctioning body, defined by what Frank terms “medical talk.” Medical talk “uses disease terms that reduce the body to physiology”; disease makes “my body, my ongoing experience of being alive, objectified” (Frank, 1991, p. 12). Illness, by contrast, is the subjective “experience of living through the disease,” an experience

that is shaped both by medical treatment and cultural attitudes toward the disease (Frank, 1991, p. 13). Thus, in order to describe his experience of cancer, Frank devotes one chapter to chemotherapy (the treatment required by the disease) and another to stigma (connected to the social meanings given to illness). “Saying the word ‘cancer,’” Frank writes, “my body began to defend itself. This did not happen when I was having heart problems. A heart attack was simply bad news. But I never stopped thinking that cancer said something about my worth as a person” (Frank, 1991, p. 51).

The distinction between illness and disease made by Sontag and Frank resembles that between sex and gender, body and race, differently functioning bodies and disability – a physical manifestation intertwined with a social and cultural system of signification. Although intellectually we may separate the biological and the cultural – after all, we have different words for these realms – in reality biology and culture are so interpenetrated that an individual’s felt experience of disease/illness is shaped by both. A useful book for exploring this interweaving of disease, illness, and culture is David B. Morris’ *Illness and Culture in the Postmodern Age*, which draws on postmodern theories of culture and representation, the social history of medicine, and social analysis. Morris looks at the ways in which illness is always “in part created or interpenetrated by culture.” He acknowledges that currently “a science-based biomedical model” of illness still dominates that “reduces illness to the operation of mechanical processes” (what Arthur Frank terms “medical talk”). This prevailing medical view wants to separate biology from culture and view physical or mental impairments as solely body-based disease. Morris challenges the hegemony of the biomedical model, contending that “*Illness is always constructed at the crossroads of biology and culture*” [italics mine]. This position is, as he

observes, “historically new way of understanding illness” that has begun to emerge in the last decades of the twentieth century (Morris, 1998, p. 5).

Stigma

In order to explore the meanings of illness in American culture, we have to understand the concept of stigma. Originally the word refers to a visible sign of a person’s deviance, pollution, or social marginality. In the Middle Ages, lepers were required to ring a bell as they walked; in India, untouchables had to walk with their eyes cast down, and not to drink from the same well as people of higher castes; in contemporary America, people turn their eyes away from those with visible disabilities. Those who visit the Franklin Delano Roosevelt memorial in Washington will not be able to see the president in a wheelchair: the statue shows a seated Roosevelt, his legs covered by a swirling cloak.

When the illness or social practice that a society views as deviant is invisible – as is the case with homosexuality, AIDS, and mental illness – the person may choose to “pass,” hiding the invisible, stigmatized identity. Even after his death, Franklin Delano Roosevelt could not be portrayed as someone who was paralyzed. “When Roosevelt’s Hyde Park, New York, home became a museum . . . his leg braces, well worn and painted black so as not to shine against his black socks, went on display, and then were removed” (Black, 1996, p. 261). Museum curators had decided that the public would find this visible sign of the president’s infirmity “offensive” (Black, 1996, p. 262).

To break silence and speak the truth may mean social ostracism. When she published her memoir of her struggle with bipolar disease, *An Unquiet Mind*, Kay Redfield Jameson – a

respected psychologist at Johns Hopkins University and co-author of the standard textbook on manic depression – knew she was taking a professional risk. How would her colleagues and patients respond, if they knew she had the same disease as some of her patients? Would her hospital privileges be revoked? Jameson did not suffer these forms of censure, but given the stigma mental illness carries in American culture, it is understandable that she feared her memoir might cost her professionally.

Stigma, then, may be an aspect of “illness,” of the cultural values and stories attached to disease. Arthur Frank speaks of his struggle with the visible stigmas of cancer, hair loss and his intravenous line. When he dressed he would wear loose fitting clothing to conceal the bulge the line made across his chest. Dealing with the hair loss caused by chemotherapy was more traumatic. “Cancer made baldness into a stigma; I imagined others seeing me as a cancer ‘victim.’” (Frank, 1991, p. 93). As a sociologist, Frank knew that stigma was a socially-constructed concept, not an inherent value, and yet he could not fully reject the cultural definition of cancer as deviant. And that meant he did not simply experience a disease – he felt damaged as a person. “I experienced the visible signs of cancer as defects not just in my appearance, but in myself,” Frank writes (Frank, 1991, p. 92). Contrasting his experience of heart disease with cancer, he concludes that the “difference between heart attack and cancer is stigma.” (Frank, 1991, p. 91).

People who suffer from cancer cannot help internalizing social values and feeling themselves personally defective. Stigma and silence are always connected; as Frank observes, “Every attempt to hid cancer, every euphemism, every concealment, reconfirms that the stigma is real and deserved.” (Frank, 1991, p. 97). Arthur Frank had experienced a heart attack several

years before his cancer, and because that illness does not carry the negative associations of cancer, he writes that “My heart attack damaged my body but did not stigmatize it. . . . The damaged body only fails to perform properly; the stigmatized body contaminates its surroundings” (Frank, 1991, p. 92).

The Meanings of Depression

The stigma of cancer – debilitating as it is – is not as intense as the stigma assigned to mental illness in American culture. People who suffer from cancer do not, as a rule, fear dismissal from work if they are managing their disease through treatment, but people suffering from depression (and other mental illnesses) are reluctant to inform employers and co-workers of their conditions, even when they are successfully managing them with treatments such as antidepressants, therapy, nutrition, and exercise. Many people who suffer from mental illness must “pass” at work because they fear that the stigma would make them subject to shunning and perhaps dismissal. “You never tell at work,” is the wisdom passed on at the Boston chapter of MDDA (the Manic-Depression and Depression Association), which I attended on a weekly basis during a sabbatical year I spent in Boston.

Such was the stigma and the culture’s wish to deny and avoid the subject of mental illness that it was not until 1999 that the Surgeon General of the United States (David Satcher) published the first report on mental illness in the history of the Surgeon General’s office. *Mental Health: A Report of the Surgeon General*. Department of Health and Human Services. U.S.

Public Health Service. Significantly, the report began with a discussion of the stigmatization of people with mental illnesses and argued that stigma “must be overcome.”

Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders. . . .It reduces patients’ access to resources and opportunities (e.g. housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious forms, stigma results in outright discrimination and abuse. Most tragically, it deprives people of their dignity and interferes with their full participation in society. (*Mental Health*, p. 6)

Depression as Disease

Over the last fifteen years, medical understanding of the biochemical sources of depression has increased dramatically. Researchers have explored the role of neurotransmitters in the brain (such as serotonin and dopamine) in causing depression, and pharmaceutical companies have developed new antidepressants that target neurotransmitters. The new category of antidepressant medication is termed SSRI (Selective Serotonin Reuptake Inhibitors); Prozac, the first in this category, is the most well-known, but many others have been developed, including Zoloft, Paxil, and Lexapro. (We can see the shifting popularity of SSRI antidepressants in *The Sopranos*: in the first season, Tony is given Prozac for his anxiety and depression, while in the last season his son A.J. goes on Lexapro.) More recent research has focused on genetic sources of depression. Most researchers agree that people inherit a genetic predisposition for depression that will lead to the disease when triggered by a variety of causes, including stressful

life events, chronic losses and pressures (such as those caused by discrimination and poverty), and disturbed or traumatic childhood. “Genes and environment interact at every level,” Peter Kramer observes; “genes and experience are thoroughly mingled” (Kramer, 2005, pp. 138-39)

In his book *Against Depression*, Kramer announces in his “Prologue” that he is writing a “polemic, an insistent argument for the proposition that depression is a disease, one we would do well to oppose wholeheartedly” (Kramer, 2005, p. xi). In a chapter called “Magnitude,” Kramer concedes that “inevitably” people will express doubts “about depression’s gravity.” And so he asks the question: “Looking at the range of illnesses that afflict human beings, just how bad is depression?” His answer may strike many as surprising because of our failure, as a society, to take depression seriously.

This question has been answered with some decisiveness in the past fifteen years. Because public health dollars are scarce, statisticians have worked to quantify the harm diseases cause. Their findings have surprised even the researchers who devised the major studies. Depression is the most devastating illness known to humankind. This result holds across the board—in the developing world and the industrialized nations, in current surveys and in the projections of future health care needs. (Kramer, 2005, p. 150)

Some physicians have referred to an American “epidemic” of depression in the late twentieth century, and the statistics are certainly staggering. The risk of depression for people born since 1960 is from three to ten times greater than the risk was for Americans born in 1900 (Morris, 1996, p. 62). Over the course of a lifetime, one in four women will suffer a major depression (and one in eight men). So major depression is diagnosed twice as often among

American women – although it could be that women are more likely than men to name their distress and to seek help (Morris, 1996, p. 227). The consensus is that around 11 million Americans will experience major depression each year, and the cost to the economy from missed work days, lowered productivity, and health care runs around 43.7 billion annually. People suffering from major depression are twenty times more likely to attempt suicide than the general population, and the most common predictor of suicide – after a previous suicide attempt – is major depression. “In fact,” observes Kay Redfield Jamison in *Night Falls Fast*, her study of suicide, “some type of depression is almost ubiquitous in those who kill themselves” (Jamison, 1999, p. 103).

To some extent, in the late twentieth and early twenty-first century Americans seemed more open to acknowledging the existence of depression. Like gays, some depressives are coming out of the closet, and it might seem that the stigma surrounding depression has begun to fade – thanks in part to the attention-grabbing success of Prozac. Depression is more acceptable now than it was in the 1950s, when my father took the risk of telling the truth about what he called “nerve exhaustion” in his 25th reunion report for his Harvard classmates. We have National Depression Screening Day, memoirs of depression by writers like William Styron, Martha Manning, and Tracy Thompson. As a response to such writing, the Library of Congress created the new category “*Depressed persons – United States – Biography.*” We have Mike Wallace and Tipper Gore acknowledging their struggles with depression on national television, personal essays in the *New Yorker* and *American Scholar*, sessions on depression and narrative at the Modern Language Association. We have chatrooms, websites, support groups, advertisements for Prozac and Zoloft in mass-circulation magazines like *Time* and *The Ladies’ Home Journal*. Peter Kramer’s *Listening to Prozac* spent months on the *New York Times* bestseller list, and “Depression” is now a separate shelving category at Borders and Barnes and Nobles, a sure sign that an illness is topical, even “hot.” There is even an online depression bookstore (*Depressionbookstore.com*).

Depression is now acknowledged to be multicultural by the drug companies: Prozac is making pamphlets for African Americans and Hispanics, identical to those for whites except for a few tag lines (“*If you think that suffering from depression is just another part of what it means to be African-American, the information here could help you . . .*”). *Hispanic-Americans suffer from depression just like a lot of people Depression*

speaks many languages. . . .Depression does not discriminate.”) The online bookstore has a separate category for “Women of Color,” and the National Mental Health Association publishes a booklet called “Depression and African Americans: Not ‘Just the Blues.’”

But such media attention is misleading. Americans are far more comfortable talking or joking about antidepressants – the supposed “quick fixes” – than in acknowledging the far darker reality of depression, which in many cases cannot be permanently “cured” by pill-taking, even though antidepressants are usually essential to managing depression. A friend of mine, during a recent stay at a writer’s colony, told me she’d boldly asked at dinner “Okay, so how many of us are on Prozac?” and reported that “Five out of eight raised their hands.”

“So did you talk about depression?” I asked.

“Oh no,” she said. “We just did the poll.”

All mental illnesses in the United States are marked with stigma – this is one reason for the lack of parity in health plans between benefits for mental and physical illnesses (an artificial distinction in any case). Most health plans have similar imbalances, as well as smaller reimbursements for therapy visits, in contrast to visits to internists or pediatricians.

But there’s a particular kind of stigma surrounding depression, despite the fact that this is our most widespread form of mental illness. The reason is not just the dreadful suffering but also the resulting hopelessness, the loss of faith in the future and the possibility of recovering. William Styron describes this slippage into despair in *Darkness Visible*:

Despair. . . comes to resemble the diabolical discomfort of being imprisoned in an overheated room. And because no breeze stirs this cauldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion. (Styron, 1992, p.)

Here we have one of the “un-American” qualities of depression America is, above all, founded upon faith in progress and the belief in positive transformation: this is the land where one can always escape from a confining past, whether in this country or another, start over, and find a new life. It’s the loss of hope and faith in the future being better than the past that marks depression as the dark side of the American dream and makes it such a lonely illness, because what American wants to confess to such unpopular – and frightening – beliefs and feelings?

One reason Peter Kramer must take a stand “against depression” and write a polemic declaring that it is a disease, as real as cancer or diabetes, is because many people in contemporary America do not believe that depression *is* a disease. People who suffer from depression are thought, somehow, to be malingerers – if they only tried a little harder, couldn’t they just get out of bed and get on with it? (One of the nineteenth century terms for depression was “hypochondria,” and the word’s slippage into meaning “imagined illness” is not accidental.)

Part of the reason for the refusal to take depression seriously is the fact that the illness is invisible – there’s no blood test for depression, and so it’s hard to “prove” that one is suffering from something verifiable and nameable. But more important, I think, is the fact that depression is an un-American inactivity, a deviant state in a culture devoted to self-reliance, upward mobility, and the work ethic. The depressed person flagrantly

violates cherished American values – work, productivity, energy. Depression enacts the crumbling of the will, the inability to act, and the failure of self-reliance: these are blows to our dominant ideologies and assumptions about reality. Americans like the “up-by-your-bootstraps” narrative of individualism and will power; those who have never experienced depression cannot understand how the disease cripples the will and erodes the soul, and so viewed those who suffer from the disease as weak-willed and self-indulgent.

Every time I teach Benjamin Franklin’s *Autobiography* or Horatio Alger’s *Ragged Dick* – key narratives of upward mobility -- I think “there’s no place for depression in these stories.” The progenitors of the “up by your bootstraps” story of upward mobility, Franklin and Alger want all time to be filled with productive activity. “Lose no Time,” writes Franklin. “Be always employ’d in something useful.” Franklin connects such constant industry with the power of the will – which shrivels in depression – which he calls “Resolution.” “Resolve to perform what you ought,” he counsels. “Perform without fail what you resolve” (Franklin). Recently I published an article on “Women and Depression” in a local magazine, and received a phone call from a woman suffering from chronic depression. “How have you managed?” she asked me. “When you’re depressed, how do you keep your house clean?” “I don’t keep my house clean,” I said. Franklin would have said “*Resolve to keep your house clean.*”

I look at Franklin’s schedule for the day in the *Autobiography* – rise at 5:00, work, read, dine, work, supper, conversation, sleep, every hour accounted for, every hour filled, and I think about what my days are liked when I’m depressed. Stay in bed as long as possible, try to avoid the despair. Get up. Go to work. Put all your energy into passing as

normal. Stare out the window for half an hour. Come home. Watch TV. Listen to the furnace go on and off. Wait for the earliest possible bedtime. “When I was depressed and the kids were in school,” a woman in my depression support group confessed, “after everyone left the house I’d get back in bed and spend the day there.”

We never experience an illness in a “pure” or absolute sense: we always experience it through the filter of meanings culture attaches to it. And so when Americans enter depression’s dark kingdom, they interpret it through the cultural metaphors and stories they have inherited, often internalizing stigma and shame. “Sometimes I recognize that I have an illness like any other,” said a man in the MDDA support group. “But at other times I really judge myself harshly and think I’m a bad person.”

Conclusion: Suggestions for Further Research

In order to explore the various meanings attached to depression in contemporary American culture, it is important for health studies students and scholars to analyze a wide and varied range of sources. Those who wish to read memoirs of depression can begin with William Styron’s classic *Darkness Visible: A Memoir of Madness* and then turn to more recent memoirs such as Martha Manning’s *Undercurrents*, Andrew Solomon’s *The Noonday Demon*, and my own *The Family Silver: A Memoir of Depression and Inheritance*. The best book for placing depression narratives in the larger context of illness narratives would be Arthur Frank’s *The Wounded Storyteller*; in this study Frank discovers three narrative types of illness narratives, and these are useful rubrics for considering the ways in which writers tell stories of depression. Juxtaposing

Peter Kramer's *Listening to Prozac* and *Against Depression* are key texts in showing how one important commentator moved from underestimating the seriousness of depression to understanding and emphasizing it; the fact that *Listening to Prozac* became a best-seller and *Against Depression* has been relatively ignored can help students analyze cultural attitudes toward medication and depression.

It is important, however, not just to read books authors and experts who have the cultural capital to be published by mainstream publishing companies. We need to discover how “average” people – those who do not write and publish memoirs or medical commentaries – experience and describe depression. To what extent do people resist – and/or internalize -- stigma? How do they cope with depression as both disease and illness? How do they view medication? Do they believe in recovery, or do they view depression as a life-long illness to be endured and managed? A place to begin addressing these questions are two books by David Karp, a sociologist who bases his qualitative analysis on dozens of interviews: *Speaking of Sadness: Depression, Disconnection, and the Meanings of Illness* (1996) and *Is It Me or My Meds? Living with Antidepressants* (2006). The websites of the National Alliance on Mental Illness and the Depression and Bipolar Support Alliance contain links to support groups and chat rooms (several support groups have their own newsletters, such as MDDA's *Polar Express*); *McMan's Depression and Bipolar Weekly*, an online newsletter, contains up-to-date information on depression and bipolar disorders as well as a reading list and links to readers' comments.

Ongoing medical research is giving us more understanding of the complex biochemical sources of depression as well as new treatments. The question remains,

however, whether the stigma of depression will ever be lessened in American culture and whether the silence that surrounds the illness will be broken. Including discussions of depression as both disease and illness in health studies curricula is one way to begin.

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