"Is Depression A Disease?"

Debatesdebates
Produced by Warren Steibel
Taped: March 31, 1998, New York
Show #235, Aired the week of May 13, 1998

NO

Thomas S. Szasz, M.D.
Professor Psychiatry Emeritus
SUNY Health Science Center
Syracuse, New York

Jeffrey A. Schaler, Ph.D.
Adjunct Professor
School of Public Affairs
American University
Washington, D.C.

Ron Leifer, M.D.
Psychiatrist & Author
The Happiness Project
Ithaca, N.Y.

YES

Donald F. Klein, M.D.
Director
Department of Therapeutics
N.Y. State Psychiatric Institute

Frederick K. Goodwin, M.D.
Former Director, NIMH
Center for Neuroscience,
Medical Progress & Society
George Washington Univ.
Medical Center
Wash., D.C.

Peter Kramer, M.D.
Professor & Author
Listening to Prozac
Brown University
Dept. of Psychiatry &
Human Behavior

MODERATOR: Welcome to this week's television debate, "Is Depression a Disease?". I'm Martin Nix, I'm the time keeper and part time referee. Let's get ready to start our introductions. Dr. Donald Klein.

KLEIN: My name is Dr. Donald Klein. I am Professor of Psychiatry at Columbia University and Director of Research at the New York State Psychiatric Institute. My work with depression started about forty years ago, when we were studying the first anti-depressant, Tofranil. We found that patients who could have no joy in life, no pleasure,

profound insomnia, anorexia, lost weight, were often suicidal, when given Tofranil, nothing much happened for a couple of weeks, and then after two and a half, three weeks, remarkable changes occurred. They would say things like the veil has lifted, I am suddenly able to live again, I can be a person. Now, what was astounding about this, is that that drug, when given to ordinary human beings, did not make them happier. It had practically no effect upon ordinary people. Therefore, depression, clinical depression, is not unhappiness, it is an illness that is open to medication and can be medicated well. It is that elementary fact, that the antidepressants do little to normals, and are tremendously effective in the clinically depressed person, that shows us that this is an illness.

MODERATOR: Thank you, Dr. Thomas Szasz.

SZASZ: I am Thomas Szasz, and I am here and my colleagues are here to discuss whether depression is a disease. We will argue that it is not a disease. And I can show some of the basic elements as follows. A disease scientifically is defined as a biological abnormality that affects living tissues. Trees can be diseased, plants, animals, and humans. A real disease is typhoid fever, we call it a literal disease. Spring fever sounds like a disease but it is not a disease. The whale is a real animal, but it is not a fish, it is a metaphorical fish. So when we say depression is not a disease, we do not minimize the human phenomenon suffering. It exists like the whale exists but it is not a disease. Point number two: treatment has got nothing to do with disease. None of us object to psychiatry between consenting adults, when psychiatrists talk about this treatment and disease, they mean locking up people in prisons that they call hospitals, and forcing on to them chemicals that they call treatment. We have no objection to voluntary treatments, like for diabetes. And thirdly, suicide is not a medical problem. It is a moral problem, it is a legal problem, it is an existential problem. Killing oneself is as old as mankind, it is exactly like killing others, or killing animals. It's not a medical problem.

MODERATOR: Thank you, Dr. Donald Klein, would you introduce your first teammate?

KLEIN: Yes, Fred Goodwin is Professor of Psychiatry at George Washington University, and formerly Director at the National Institute of Mental Health, he has been an eminent researcher in the area of depression for over thirty years.

GOODWIN: I'd like to be philosophical as Dr. Szasz was. The concept of disease in medicine really means a cluster of symptoms that people can agree about, and in the case of depression we agree 80% of the time. It is a cluster of symptoms that predicts something, it predicts a natural course, an outcome, it predicts the way in which treatments work or don't work. Now, one thing we don't realize very much is that in the case of the reliability of a diagnosis, that is, how much do people agree, actually depression ranks up there pretty high with the rest of medicine. I don't think many people realize that doctors looking at a mammogram to tell a woman whether she has breast cancer, agree 67% of the time, whereas doctors interviewing a depressed patient to see whether they have clinical depression, is 80% of the time. In fact, it's right up near the top. I think the issue is that in depression, in "big D" depression, we often confuse,

it's a semantic issue, we confuse the state of being depressed with the disease of being depressed, which involves a lot more than feeling and thinking, it involves a whole bunch of physiological disregulations. And now, in terms of this issue of whether we know something about the pathology of the disease, I think brain imaging is making these arguments a little bit dated. Because in fact now we can look at brain images with PET scans and MRIs, and see that there are differences in depressed patients and people who are not depressed.

MODERATOR: Thank you, Dr. Szasz, your first teammate.

SZASZ: I am happy to introduce Dr. Jeffrey Schaler, my friend and Adjunct Professor at American University.

SCHALER: Thank you, Tom. Well, right off the bat I see we disagree. And I see that our opponents are already confusing diseases with behaviors. Now, depression most certainly is not a disease, because depression is a word that we use to describe activity, and activities are behaviors based in values. They aren't physical, they are ways of moving in the world. Now, if by a disease you mean something physiological, if you have a particular way of deciding that a person's brain is not producing enough serotonin, for example, or uptaking enough, or there's a problem in uptake or transmission of serotonin, then perhaps what you've discovered and outlined would qualify as a bona fide disease. In that case, though, you don't rely primarily on activity or symptoms, I beg to differ, a diagnosis is not made on the basis of a cluster of symptoms, it is made on the basis of a cluster of signs. And when we talk about signs in medicine we are talking about physiological lesions, neurochemical imbalances, etc. Depression is not found in a corpse at autopsy, because depression does not refer to anything physiological, it refers to how a person conducts himself, or moves in the world. Thank you.

MODERATOR: Thank you, Dr. Klein, your final teammate.

KLEIN: Yes, our next discussant is Dr. Peter Kramer. Dr. Kramer is Professor of Psychiatry at Brown University. He is the author of the extremely well known and excellent book, *Listening to Prozac*.

KRAMER: Thank you, Donald. I am very pleased to be on this side of the aisle because I have written a couple of books, *Listening to Prozac*, and *Should you Leave?*, that concern the minor chronic states of depression that verge into personality styles. And I think there, there's lots of room for debate, and lots of interesting reasons perhaps to say that culture may do better to call those something other than illnesses. But, the core element, the core disease depression I think is now indisputable, and I think we might as well end the debate right here and go on to the second issue of the extent of the disease. I think Dr. Schaler is willing to say that if we can find changes on autopsy that characterize someone who is severely depressed, he's going to come on over to our side, maybe Dr. Szasz would like to, as well. And it certainly is true that people who have died, males who have died violent suicides, have characteristic low levels of brain serotonin. This is

something that has been researched around the world. And, so I think there is a core illness that is depression. And we have to go on to say, what is its extent?

MODERATOR: Thank you, Dr. Szasz, your final teammate.

SZASZ: I am happy to introduce my friend Dr. Ron Leifer, a practicing psychiatrist in Ithaca and author of *The Happiness Project.*

LEIFER: Thank you, Dr. Szasz. And not so fast, Dr. Kramer. I don't think the discussion is over yet. Just the title of this program, "Is Depression a Disease?" I think reveals the weakness of your side. Wouldn't it be foolish if we were sitting here discussing, "Is Diabetes a Disease?," or "Is Pneumonia a Disease?" That, the fact that we are discussing this reveals that there is some question about it. Also, the question "Is Depression a Disease?" is not a factual question. We're not going to find disease anywhere in nature, it is a name, and the question is should we use that name with all its implications or not? In my view, your side is emphasizing the biochemical changes. In my view, I'm calling it a disease because presumably there are biochemical changes, and I'm willing to concede all the facts, all the facts that you fellows have found in laboratories, given that they are properly discussed, debated, and criticized, which I don't think is true. You guys are in the majority, you've got the forces of propaganda, you've got the psychiatric establishment, you've got the pharmaceutical industry, all saying that depression is a disease caused by a biochemical imbalance. We have been for thirty years trying to get to this point where we have an opportunity to debate you. Now that we have this opportunity I'd like to say that I have a different view of depression. In my view, and I'm a Buddhist, which is shown by my book, in my view, depression is a spiritual problem. The main symptoms of depression are hopelessness and helplessness. The main problem is that we're all living life with hopes and with some desire to control our lives. If our hopes are unrealistic, our hopes are going to be dashed. In my view, depression is dashed hope, and a feeling of being out of control of one's life. Depression is about the future, it's a sense of not having the possibility of being happy in the future. When we get into this kind of spiritual predicament, our body can bog down. I think that the spiritual problem causes changes in the body, so that all those changes are present. The question is, are they cause or effect. I think they are effect rather than cause, an effect of a spiritual problem.

MODERATOR: Thank you. Well, you're opportunity has arrived. We're ready to start the debate. Thomas Szasz, you can stand up. First question from the other side.

KLEIN: Thank you. Dr. Szasz, isn't it so that there have been many diseases that have been identified in medicine long before we had any idea of what the biological difficulty was?

SZASZ: That's correct.

KLEIN: Therefore, why do you take the stand that these illnesses we refer to as depression, cannot be a disease, it cannot simply be that we have not yet identified the biological changes that cause that disease?

SZASZ: It cannot be identified for the reasons Dr. Leifer already mentioned, because its initial position from which it is identified is a purely subjective reaction, like pain from stimulus. So it is not a disease it is a perception. But also, my argument, as I stated it right off, is two-pronged. I am willing for the sake of the argument, and I personally resent the idea of wanting to come over to another side. I have had forty years of experience of coming over to the other so I don't need any invitations. The other side, in my opinion, uses the term disease to lock up people, deprive them of liberty and deprive them of responsibility. You can give people all the antidepressants you want, as far as I am concerned, I just don't want you to give them to people who don't want them. So the idea of depression is not the only issue that we are discussing here.

KRAMER: I think you have come over to the other side if you say you can give all the antidepressants you want, under the rubric of medicine, only don't lock up people. Because then we're having a political debate, not a medical debate. I think that your work has been very important over the past forty years in asking psychiatry to distinguish between two models: one, the psychotherapeutic model, which I think you've attacked actually quite successfully, and the other medical model. And I think you have said, in your mind, the right standard for psychiatry is that disease has to be physiochemical and it has to have effects on organ systems. And I say that if you would like to declare victory and go home, you may, I think that psychiatry has risen to that challenge, has shown that depression has physiochemical causes and effects. And we can give medications that in a percentage of people will reliably produce the whole syndrome of depression.

SZASZ: Excuse me, I don't want to interrupt, but you are never addressing the issue of involuntary treatment.

KRAMER: No, I wanted to discuss "Is Depression a Disease?"

GOODWIN: That's a separate debate, I think. It's an important debate but a separate one.

SZASZ: It's not a separate debate because a word means its consequences. You don't get the meaning of words from a dictionary, floating around. If mental disease means, why do we have separate hospitals for mental diseases and medical diseases? Why can you plead insanity? I mean . . .

GOODWIN: As you yourself said, we don't involuntarily treat people for medical diseases. I'd like to as you . . . do you think Alzheimer's is a disease?

SZASZ: Of course it is a disease.

GOODWIN: And it involves behavior?

SZASZ: Of course it involves behavior. Doesn't having a cold involve behavior?

GOODWIN: You said if it involves behavior it couldn't be a disease.

SZASZ: No, you don't diagnose it, Alzheimer's, if I may remind you. Who discovered Alzheimer's? A pathologist, on the corpse.

GOODWIN: Now they are close to diagnosing with brain imaging . . .

SZASZ: Brain imaging is a great scientific discovery.

GOODWIN: Now they do that with depression as well, you are aware of that?

SZASZ: Of course I am aware of that.

GOODWIN: So here you have two illnesses, one we call Alzheimer's which you say is a disease, it involves a whole range of behaviors, feelings, thinking, behaviors. There's another one that involves behavior, feelings, thinking, behaviors . . .

SZASZ: But depression is a highly reversible phenomenon.

GOODWIN: Is that your criterion for disease? What about pneumonia?

SZASZ: No, but Alzheimer's is not.

GOODWIN: Does that mean diseases are not reversible?

SZASZ: Look, the criterion for disease is not made by you and me. As you know, depression is not listed in textbooks of pathology. Maybe when it's listed in textbooks of pathology I might be willing to concede, like Dr. Klein suggests, that it's like neuro-syphilis or epilepsy, the history of medicine, it's quite correct, you discover new diseases, like AIDS.

GOODWIN: Periodic fever, is not listed either, because there's no pathology we know of, but it's a disease.

SZASZ: That's a borderline case. Do you recognize the existence of metaphoric diseases?

GOODWIN: I'm not sure what you mean.

SZASZ: I just told you, a whale is a fish, it is a metaphoric fish. Now if you don't know what a metaphor means, then we can't discuss it, because our contention is that this is a metaphor that has gone amuck.

GOODWIN: I think you are mixing together the symptoms of depression with the whole syndrome.

SZASZ: No, we are making the distinction between literal and metaphorical diseases. Is spring fever a metaphorical disease or not?

KRAMER: I think our contention is that depression is a literal disease.

SZASZ: What about involuntary treatment?

KRAMER: The problem with a debate against depression as a disease is its two-pronged, and I think your side tries to take the easier side of each prong. That is you say, on the one hand disease is socially constructed, but depression is constructed wrongly socially. On the other hand, disease must be physiological, which by the way, I disagree with, that diseases must be defined on the basis of known pathophysiology.

MODERATOR: Do you have a quick answer to that?

SZASZ: Well, I come down to the fact that words mean their consequences. I am not willing to disconnect the debate of "Is Depression a Disease" from involuntary treatment. Because you can call anything anything you want.

MODERATOR; Thank you. Dr. Donald Klein, it's your turn.

SCHALER: Dr. Klein, you cited the fact that when people take certain kinds of drugs they feel better as supporting the existence of depression.

KLEIN: I think you misunderstood me. I said that when normal people take these drugs, they don't feel better, that's the essential difference. I said that when depressed people that can be clinically defined in terms of their syndrome, their anorexia, their insomnia, when they take their drugs, they don't feel better right away, and then several weeks later they feel better.

SCHALER: And that's true across the board, so every one who feels better from taking Prozac, for example, was suffering from some abnormal level of serotonin, is that correct?

KLEIN: That is an unnecessary corollary to what I'm saying. I'm saying, I can define a person's disease, and I can treat it. You're trying to say anything the drug does defines the disease.

SCHALER: But how is it, can you take blood and diagnose a person for being depressed in terms of low serotonin levels?

KLEIN: I would like to be able to, we're not at that point yet.

SCHALER: You can't, so you diagnose primarily through symptoms.

KLEIN: In medicine you move forward and you understand things better as you go along.

SCHALER: So you cannot diagnose someone by taking a normal blood test and seeing whether they are depressed or not?

KLEIN: Of course not.

SCHALER: Is there such a thing as asymptomatic depression?

KLEIN: That's an oxymoron.

SCHALER: You have to have certain behaviors and activities in order to make the diagnosis?

KLEIN: No, you have to have certain things such as an inability to respond to pleasure.

SCHALER: But that is a behavior, though, that's an activity.

KLEIN: I'm sorry, I don't consider that a behavior in the sense of doing something.

SCHALER: You don't differentiate . . .

KLEIN: It's a deficit state. Here's a steak, does it taste good to you? No it doesn't taste good to me. Is that a behavior or is that a statement that the person is unable to respond with pleasure to a definite stimulus.

SCHALER: You are referring to a behavior and that is a strategic maneuver.

SZASZ: But is having pleasure or not having pleasure a medical issue?

KLEIN: Why shouldn't it be? What if you have hyperthyroidism and you can't have pleasure, either?

SZASZ: What is the mother of Jesus called in Latin? Mater Dolorosa. You look to museums, what do you see? Depressed people . . .

KLEIN: You are trying to confuse me . . . you're trying to confuse unhappiness with depression, not the same thing.

SZASZ: No, you are trying to confuse it.

KLEIN: No, I'm sorry, you did by bringing the Mater Dolorosa thing. Let me point out something else. . .

LEIFER: How do you know it's not the same thing? You are just simply saying that. You are defining that they are not the same thing.

KLEIN: Very simple, I have given antidepressants to normal people and they don't get happy.

LEIFER: I had a patient last week who said, "Don't tell me I'm depressed, I want to talk about sadness, if I talk about depression, you're the expert. If I talk about sadness I'm the expert. This is arbitrary, we can call it whatever we want. To me, depression is sadness.

KLEIN: I don't think patients should define the issues. The patient doesn't define the issues, it is a medical issue. The patient says, "I don't want to call it depression", you say "ok, that's not depression, that's terrific".

LEIFER: But that's because you have the power to define it. How do you know that the physical changes are the cause or the result of the depression? In my view they are the result.

KLEIN: All right, then, you have to explain the genetics of depression.

LEIFER: You don't have to explain the genetics of depression because the genetics could refer to temperament. Research has not been done on the relationship between genetics and temperament. I would likely concede that there is a relationship between genetics and temperament. Every animal breeder knows it and everybody who has got more than two children, three children knows that temperament could be inherited. So the fact that you can find that people with some kind of a temperament are more prone to depression doesn't mean the genes caused the depression. It means that people have different physiological and genetic equipment to deal with life.

KLEIN: You're saying that A doesn't lead to C, A goes through B to lead to C, so what?

LEIFER: Let me give you an example, it's the last second in a basketball game, my team scores a goal, I get very happy and excited, the catacholamines in my blood go up. Am I excited because of my catacholamines or am I excited because my team won the game? I think the analogy is exact, people become depressed because life doesn't go their way. Their serotonin level goes down.

KLEIN: A lot of people become depressed for no apparent reason whatsoever.

LEIFER: For no apparent reason you see, I see it, you don't.

KLEIN: You don't really see it. Of course *you* can see people the most.

SZASZ: But it's very difficult to see something you don't want to see.

LEIFER: Exactly.

KLEIN: We spent a lot of time with patients in hospitals trying to find out what got them that way, and many times we just could not.

MODERATOR: Ok, moving on to a happy Jeffrey Schaler now. Please stand up, first question from the other side.

GOODWIN: I'd like to ask, do you diagnose schizophrenia as a disease?

SCHALER: No.

GOODWIN: Ah…and have you talked to parents of schizophrenic children?

SCHALER: I've talked to parents of children, but I have not talked to parents of schizophrenic children.

GOODWIN: And do you diagnose manic-depressive illness as a disease?

SCHALER: No, no.

GOODWIN: And how do you understand manic-depressive illness, when people have regular recurrence like clockwork . . .

SCHALER: I understand manic-depressive illness as a metaphorical illness, people get sad, people get angry, and a lot of times they have a lot of good reasons for being sad and angry.

GOODWIN: How would you deal with . . . I treat a lot of these severe patients . . . you don't, you're not a physician, but, I understand that limitation, but when a severely depressed patient comes into my office, they can't stay asleep, their mind is so slow they talk about "it feels like molasses", they can't remember anything, they can't possibly experience, everything literally looks gray, their mind is as shutdown as the mind of the Alzheimer's patient, my mother has that, and I know what that feels like. Who can't literally think of one thing to the next or even tell where she is. Now this is a brain disease, are we, the mind . . .

SCHALER: Now wait a minute, you're confusing again, you're confusing behavior with brain disease.

GOODWIN: The mind is a disorder, the mind depends upon the brain, would you agree with that?

SCHALER: We can't speak of minds as independent of brains, in the sense; of course, to speak of brain as independent of mind, we're talking about a dead person.

GOODWIN: So if you have the mind as dependent upon the brain, and intertwined with the brain, then if you have a disease of the brain, it will be a disease of the mind.

SCHALER: No, not necessarily. People have diseases of the brain and they don't have what you call mental illness.

GOODWIN: That's true, but it depends on the area of the brain you are talking about.

SCHALER: But I'm not sure what your question is. What do I do with people you might diagnose as clinically depressed? What do I say to those people? Well, again if they are coming to see me willfully I assume there's something they want to talk about, and what I look at is how the activity that you call depression is in fact a strategic maneuver that is used by these individuals to avoid coping with experience.

KRAMER: Right, sometimes you are making the terrible mistake, there have been ethical mistakes on each side, the terrible ethical mistake of trying to make people morally responsible for things which very likely they have no moral responsibility for.

SCHALER: Although I did anticipate this, you seem to work two sides of the street. On the one hand, you say, and I'm really curious as to how you reconcile this information. On the one hand you write the foreword to Louis Fierman's book, talking all about how these problems are existential problems. These are existential problems. And on the other hand you talk about how they are biological problems.

KRAMER: My criteria for mental health is the ability to walk both sides of the street and I want to know whether you can walk the other side of the street.

SCHALER: Well, according to psychiatric literature, some people call that psychosis.

KRAMER: Let's start with pseudo-dementia. You asked whether people can be depressed who give no indication, don't indicate through their own words that they are depressed. There are people who are elderly, severely depressed, they are in the hospital, they are misdiagnosed as having dementia, if someone comes around and thinks to give them an antidepressant, they get better. They get fully better; they have an undiagnosed reversible disease. We don't always diagnose . . .

SCHALER: Saying that over and over doesn't make it so. People smoke marijuana . . . .

KRAMER: I'm sorry, what's not so?

SCHALER: Saying that they have a brain disease doesn't make them have a brain disease. Now people take all kinds of drugs, legal and illegal, and they feel better as a result. Are you saying that people who use marijuana, snort cocaine, or shoot heroin all

have brain diseases? And that's why they use these drugs? They feel better from them. When I drink a glass of wine in the evening, I feel better, does that mean I'm suffering from wine deficiency?

KRAMER: Your question is whether depression sometimes in severe forms can be diagnosed without symptoms and solely on the basis of signs, and I said . . .

SCHALER: And how do you make that diagnosis?

KRAMER: When I say yes, I would like you to say that we have won the debate and can go home.

SCHALER: Because you are still basing your diagnosis on behaviors. Are you taking blood? Are you taking an MRI and basing a diagnosis on signs? No, you avoid dealing with that, that's a fact. You are basing it on the behaviors and the conducts. If in fact . . .

KRAMER: I'm trying to not bluff your criteria one by one.

SCHALER: My criteria are the same as any pathologist's. If these criteria actually exist, they would be in a textbook on pathology. It's a fact! If what you say was true you would find depression in a textbook on pathology. End of story.

GOODWIN: There are many diseases in medicine for which there is no specific pathology known.

SCHALER: Yeah, masturbation, homosexuality, schizophrenia, depression, alcoholism. All of these are behaviors, misbehaviors that are socially unacceptable, that psychiatrists categorize as diseases in order to get rid of these people.

KLEIN: You know, is there a market on the street for antidepressants, like there is for cocaine, like there is for heroin?

SCHALER: Look, legal pharmaceutical companies can have the freedom to manufacture a more effective drug, makes sense to me, sure. They're competing with the illegal drug dealers.

KLEIN: I'm sorry; does anybody go out there and buy the stuff?

GOODWIN: Isn't there pathology for arthritis, osteoarthritis?

SCHALER: Because those are physiological lesions, these are real diseases.

GOODWIN: How was that diagnosis made? Osteoarthritis? How was that diagnosis made?

SCHALER: I'm not sure how that diagnosis was made.

GOODWIN: Well, I'm a physician, I'll tell you. It's made with signs and symptoms. It's made with painful joints of what people can't do. There's no pathology for that, until the person is dead you can look and see the joints are degenerate.

SCHALER: Ok, until the person is dead. Now, when the person dies with depression, what is that is equivalent?

GOODWIN: Well, if they die from suicide you can see. . .

SCHALER: No, no! Suicide is an act, that's not a physiological lesion!

GOODWIN: If they die from manic-depressive illness, you will see that they have smaller pre-frontal cortices, parts of the pre frontal cortices . . .

SCHALER: Well, why isn't that included in the standard textbook of pathology?

GOODWIN: Because we're talking about research that takes two generations to get into pathology textbooks.

SCHALER: Because it's incomplete, then. Then would you grant that that is incomplete at this time?

GOODWIN: It's incomplete in every area of medicine.

SCHALER: Will you grant that there is no gestalt of signs that would include depression in the standard textbook of pathology?

GOODWIN: If we had debated this a hundred years ago, you would be saying that diabetes is not a disease.

SCHALER: Will you grant that those signs do not exist in a way to convince pathologists to include at this time . . . ?

GOODWIN: Would you have said, in 1900, would you have said that diabetes is not a disease? I think there's a double standard here. When it involves behavior, you say, "Well, we want to avoid the concept of disease." When it involves something physical in the body, and of course, depression involves the body as well, but, when it involves behavior, we say, "Oh, we want to be careful, when it involves . . .

SCHALER: And why is it that we want to be careful? Because of what it's done to individuals in the name of diagnosing them as a disease!

GOODWIN: Well, that's a separate issue . . .

SCHALER: That's right, and what's key here is the role of the state, because of what is done, with the state. Let me make a diagnosis and if the person doesn't like the diagnosis, what difference does it make?

GOODWIN: Because it could be misused, you don't mean it doesn't exist.

MODERATOR: Don't worry, Doctor, you're up Dr. Goodwin. Please stand up. First question please, Dr. Szasz.

SZASZ: Yes. I object to the way you construct your biological criteria, they are historically unfair because forty years ago, fifty years ago, a gentleman already got a Nobel Prize for discovering the pathology of schizophrenia, reverberating circuits of the brain, there are such things as medical discoveries as lies, and mistakes, huge mistakes. That's my first point, now my second point is that I will concede that what you call diabetes/depression, whatever, let's call it "D" is a disease, as soon as physicians can diagnose it without talking to the patient or the patient's family, from the body tissues or body fluids. . .

GOODWIN: That would be good for manage care wouldn't it? (Joke)

SZASZ: This is not a joking . . .

GOODWIN: No, no, I am saying . . .

SZASZ: This is to be, diabetes can be, Dr. Klein said that asymptomatic disease is an oxymoron. That would flunk him as a freshman because asymptomatic cancer of the colon, or cancer of the pancreas is standard, you don't know that you got it, asymptomatic hypertension is standard.

GOODWIN: This is a question, I assume. The problem is that doctors have to treat things before the patients are dead.

SZASZ: They don't have to, it's voluntary . . .

GOODWIN: I mean, if a person has arthritis, they want to be treated.

SZASZ: They *want* to, they don't *have* to.

GOODWIN: They don't want the doctor to make a philosophical point and say "Well, I can't say that you really have it until you're dead."

SZASZ: A good doctor does not treat something which he does not feel is a disease, simply because the patient asks for it . . .

GOODWIN: Of course, but that's arguing by making the extreme. I'm saying that doctors all the time have to make diagnoses based on symptoms and signs, they have to

say, based on these symptoms, the likelihood that you're going to respond to this treatment is such and such . . .

SZASZ: Doctors can do anything they want, as long as the patient agrees.

GOODWIN: And by the way, in the comments about we can argue about this, the point is there's a massive amount of research in which people are put into clinical trials, they have . . .

SZASZ: But we are talking about whether or not it's a literal disease. There are literal diseases that I have my criteria for it, which has its standard pathological criteria.

GOODWIN: I think the issue of literal disease is a somewhat semantic issue. All I'm saying is that if we're saying that arthritis is a disease or periodic fever is a disease or Alzheimer's is a disease, we have to say that manic-depressive illness is a disease.

SZASZ: What about homosexuality?

GOODWIN: Now, wait a minute . . .

SZAZS: No, I won't wait a minute because homosexuals were persecuted by my colleagues in the twenty years before it was de-diagnosed. I said it, nobody listened.

GOODWIN: Homosexuality gets into this issue that you raise about biology of personality. We know now that temperament is about 50% genetic.

SZASZ: Well, suppose homosexuality is genetic, does that make it a disease? Maybe it is.

GOODWIN: No, no, of course not . . .

LEIFER: Is split personality a disease, because it has a biological basis?

GOODWIN: No, I didn't say genetic inheritance-everything is genetic . . .

SZASZ: And everything has a biological basis, the fact that you're talking is biological.

GOODWIN: I mean, you have brown eyes or blue eyes because of genetics-that does not mean they are disease.

LEIFER: And as you're talking your brain chemistry is changing. The question I would like to pose to you is, how do you know whether these changes are cause or effect?

GOODWIN: OK, because when something is persisting, week after week, month after month, and the person in spite of all their very brave attempts to will it away it won't go away.

LEIFER: At a certain point I agree with you, it won't go away. I am in private practice and I see many patients a week for forty years and yes, I have seen people who are so depressed they can't get started.

GOODWIN: Did you use medication?

LEIFER: Yes, I use medication. My metaphor for it is that these medications are like those old engines you had to crank before they got going. I don't call them medications I call them tonics, to me Prozac is a tonic. It's a very good word, it's a stimulant, it get somebody going, and then they've got to solve the problems in their life. They way you people are approaching it; you're disabling the American public. People come to me and they say, " I've got a biochemical disorder, I've got a biochemical imbalance."

GOODWIN: I've written in my book . . .

LEIFER: Excuse me . . . I say, "What chemical?" They don't know. Then I say, "Have you had a chemical test to show you you have a biochemical imbalance?"

GOODWIN: If you're questioning my views I would like you to understand them.

LEIFER: Can I finish this point? 'Cause there's a very good punch line at the end (laughing).

GOODWIN: (Laughs) Go ahead, I can't deny your punch lines.

LEIFER: I say have you had a test to demonstrate you have a biochemical disorder, they say no. I say how do you know you have a biochemical disorder? They say my doctor told me, or my sister told me or my mother told me. Depression is the only illness which is spread by word of mouth.

GOODWIN: Well, we're talking about the possibility that some people are calling themselves depressed because of all the publicity, that's of course an issue, whether there's over-treatment or under-treatment. But that doesn't get to whether there is a fundamental disorder/disease for people who have inability . . .

LEIFER: This is a word, there are physiological changes, to me they are the result of hopelessness. Just like in a baseball game or in a basketball game, if I get excited, my catacholamines go up, is that a disease?

GOODWIN: But we know that all diseases are affected by arousals, we know that ulcers can be made worse by being upset. We know that arthritis can get worse under certain conditions.

LEIFER: But what kind of spiritual problem, people want, we're disabling people by talking about biochemical disorders as if there's no aspect or dimension which has to do with the way people confront life, with the way people confront the future.

GOODWIN: It's inhumane to eliminate the spiritual from our medical work; it's equally inhumane to eliminate the helpless disease process that some people have.

LEIFER: The helpless physiological, I'm not eliminating that.

MODERATOR: Don't worry; we're not eliminating you. You're next. Dr. Leifer, please stand up.

KRAMER: I want to know whether you are not at all worried that you're doing people a disservice by taking what may, what certainly responds to medication in your practice, what may be a serious illness, and denying people medical coverage, denying people the benefits of hospitalization . . .

LEIFER: I don't do that . . .

KRAMER: . . . because you no longer define as a disease something which has been defined as a disease throughout all the history of our culture . . .

LEIFER: I don't deny people medication, if they want to go to the hospital, I'll arrange it, so what are you accusing me of?

KRAMER: And you will write on the form, please hospitalize this person, he or she has no disease, it's just a matter of pocket . . .

LEIFER: No, I'll write "depression," because the meaning of the word is to get someone into the hospital, because that's the way you guys have got it set up.

KRAMER: You'll lie on the insurance form, you'll say something you don't believe . . .

LEIFER: Yes, of course. Everyone lies on the insurance form.

KRAMER: You know, there are lots of ways of dealing with things socially, I suppose we could say, as Dr. Szasz says, words have their consequences, we could say depression is not a disease but it gives people the right to be treated vigorously with psychotherapy and pharmacotherapy, those people deserve to be hospitalized, we understand those people are at a high risk of suicide, at that point we've lost the meaning of the word "disease."

LEIFER: I don't disagree with any of that. What I would like to talk about is the problem of hope, because to me depression is a question of hopelessness.

KRAMER: Let me ask you the simplest of questions, which is, what would be sufficient for you to call depression a disease, and is there any other set of diseases that you require to meet those same criteria?

LEIFER: There's nothing sufficient to call it a disease. Depression is a state of mind.

KRAMER: No amount of evidence would convince you, then we can end the debate on other grounds.

LEIFER: Evidence of what? Let me put it to you this way, if you can find a brain disease that causes depression, then I wouldn't say depression is a disease, I would say it's a symptom of that brain disease. That happens very often.

KRAMER: It does happen often. Let's say we give one of your patients a anti-hypertensive medicine, and he has the whole syndrome, all of a sudden he can't eat, he can't sleep, he's ruminating in guilty ways, he's hopeless, and would you say, "Pull yourself together man, you have to examine your soul?"

LEIFER: Of course not, but you're using the wrong example. In that case, the drug depressed him.

KRAMER: Let's say it was estrogen and progesterone-changes in estrogen and progesterone, you would?

LEIFER: No, of course not.

KRAMER: Now, let's go to the next state, let's say it's a who woman has just delivered, who has a strong family history of depression, her progesterone level has just dropped, and all of a sudden she wants to kill her baby although this was a much-desired child, you would say that is not an illness?

LEIFER: Absolutely not an illness.

KRAMER: Because the progesterone is her own progesterone rather than one given to her by a physician?

LEIFER: Because you're looking at the progesterone and I'm talking to the woman. How do you feel about now having a baby? How do you feel about taking care of an infant? What happens in your career? Do you want to stay with your husband? We aren't asking these questions . . . .

KRAMER: And what do you make of the evidence that there's a non-random curve of when depression occurs in relationship to pregnancy? That it doesn't occur in the first month, in the third month, in the third trimester, that it quite reliably occurs two or three weeks after the delivery of the baby?

LEIFER: That's when the woman finds out what it's like to have a baby. Makes perfect sense to me.

KRAMER: And what if you could take that same woman and give her progesterone and withdraw it, and cause the same stereotype syndrome; that would not make you wonder whether her post-partum depression is also an illness?

LEIFER: Her hormonal levels may have influenced . . .

KRAMER: I think you understand that you are on untenable ground and that it's your argument that's metaphorical, you understand that depression is an illness, but for metaphorical purposes . . .

LEIFER: How can you speak to me that way? You are going a little bit too far now . . .

KRAMER: Well, I'm willing to go this far.

LEIFER: Because you're not willing to talk the language of hope, that people are interested in, when people become depressed they want to know how to deal with their lives. They'll go to you and you'll give them medicine and you won't talk to them about their lives.

KRAMER: You're speaking for people, I'd rather you speak for you than you speak for the people. I speak to my patients all the time.

GOODWIN: Do you give them medication to give them hope again?

LEIFER: I give them medication to get them out of their sloth.

KLEIN: Why does it work?

LEIFER: Because there are two kinds of psychiatric medications, ups and downs, if you're down you give somebody and up, if you're up you give somebody a down. This is not a fancy practice.

KLEIN: That is profoundly incorrect. The idea that Prozac is an up makes no sense at all, giving Prozac to people, to everybody, do not get the same up . . .

LEIFER: If depression is a down and Prozac relieves it, Prozac is an up.

KLEIN: I'm sorry? It's not an up, an up is something you give anybody and it makes them feel good.

GOODWIN: A lot of people describing that getting over a depression is not getting up, they talk about getting over the pain, getting over that terrible wired feeling-

LEIFER: That's what I mean by up, I mean if you were out on the street that's what up is, up means "I feel good", "I feel happy", "Let's go life is good!"

GOODWIN: Does that mean that Prozac is like amphetamine? Is that what you mean, that Prozac is like an amphetamine?

LEIFER: Yes.

GOODWIN: Do you know all the studies to show that people that responded to amphetamines don't respond to Prozac?

LEIFER: Look, it's in a general class of ups, of stimulants, that make people feel . . .

KLEIN: That's grossly wrong.

LEIFER: These used to be called psychiatric-energ…psychic energizers.

GOODWIN: It mostly helps the anxiety of depression.

LEIFER: So, let's classify all these ups as psychic energizers. Now, you guys are using Dexedrine for depression when Prozac doesn't work. Prozac is just one of the biggest hypes in the world.

GOODWIN: Prozac works for people who have anxious depression, not so much down.

MODERATOR: Now, let's settle down. Let's go back up over here to Peter Kramer. First question?

SCHALER: I have a question for Dr. Kramer? Do you think that feeling good is a disease?

KRAMER: Do I think that feeling good is a disease?

SCHALER: Yeah. You say that depression is a disease caused by . . .

KRAMER: That's not a serious question.

SCHALER: It is a very serious question, you're saying that feeling bad . . .

KRAMER: That's a serious question, "Is feeling good a syndrome?"

SCHALER: Wait a minute, let me make sure you understand the question.

KRAMER: No, let me answer . . .

SCHALER: No, wait a minute, you said it wasn't a serious question, let me make sure you understand it. Feeling bad, what you call depression is biologically based, now do you differentiate between feeling good, are you saying that feeling good, the opposite of the state that you call depression, is that biologically based?

KRAMER: I don't say that feeling good or feeling bad is a disease, what I say is a disease is the full syndrome of sleep disorder, appetite disorder, guilty ruminations, you ask whether you can diagnose someone without seeing the person, I would say you can't diagnose it 100%, you can't diagnose anemia 100% without seeing the person, there are people . . .

SCHALER: You know you can have a cluster of symptoms that are associated with the person . . .

KRAMER: Excuse me; I want to answer your question, because I think that this is not being well broached in the discussion . . .

SCHALER: Because you're avoiding this, and I know that you're avoiding it, you know you can have a cluster of symptoms . . .

KRAMER: I'm avoiding it? I am *diving* in, I am *jumping* in!

SCHALER: You're a very slippery guy, Dr. Kramer.

KRAMER: I'm a very solid guy answering some slippery questions.

SCHALER: You work both sides of the street.

KRAMER: I do work both sides, and I love it.

SCHALER: Yeah I know that you love both sides.

KRAMER: I think you are trying to have a debate without ambiguity or subtlety, and that is a farce.

SCHALER: You have a cluster of symptoms associated with feeling good, are these caused by the brain?

KRAMER: Are what caused by the brain?

SCHALER: Oh, *now* you don't hear, a cluster of symptoms associated with feeling good, are those caused by the brain?

KRAMER: I'm going to say cause is . . .

SCHALER: Don't avoid the answer.

KRAMER: I will give you a full answer instead of a partial answer. I think your problem is that you dislike subtlety.

SCHALER: Now you're diagnosing me.

KRAMER: I'm not diagnosing you, I'm talking to you as a person.

LEIFER: You're avoiding the question.

SCHALER: Well, I'm talking to you as a person. You know you're on shaky ground here because there's nothing left of the person if you say that feeling good is caused by the brain.

KRAMER: Now that's the trap I didn't want to walk into because there are levels of causation. That's right . . .

SCHALER: You mean, only bad feelings are caused by the brain, never good feelings?

KRAMER: Feelings are mediated by the brain, some are caused by the brain, some are caused by external events as the . . .

SZASZ: I want to raise a question.

KRAMER: We may all be caused by God in some sense but it is levels of causation that make a difference .

SZASZ: I want to raise a quite different kind of question.

KRAMER: Good.

SZASZ: In the ordinary practice of medicine, the patient comes, complains of something, the doctor makes a diagnosis, which is fancy way of saying "I think this is what's wrong with you, and I suggest you do 'Y'". Now, none of us has any objection to that.

KRAMER: Good.

SZASZ: In what way is a patient responsible for his or her depression? Let's take this post-partum psychosis that you were sketching. Do you lock up such a person against her will, yes or no?

KRAMER: No.

SZASZ: (to Goodwin) Do you?

GOODWIN: No, but that has nothing to do with whether I am going to treat her or not.

KRAMER: I might separate her from her infants.

. . .

SZASZ: If you are willing to give up all coercion in psychiatry, then I might come over to your side, but not for a minute earlier.

KRAMER: All right, well. I'm willing not to discuss coercion in psychiatry. I don't know if that's enough to make you come over to my side. I'm discussing whether depression is a disease.

LEIFER: There's no other use for the word disease.

KRAMER: There's no other use for the word disease than . . .

SZASZ: That's like not discussing coercion in Auschwitz.

KRAMER: Auschwitz? We're in Auschwitz all of a sudden?
. . .

MODERATOR: We need to move on. Dr. Klein, Dr. Szasz, please stand up. Dr. Klein, you can begin questioning first.

KLEIN: I'd like to make a point, that is, one of the things that hasn't been clear here. When we talk about disease, that something has gone wrong, that there is some function that has evolved that is now not doing its job, that's simply what's going on. Now when Dr. Szasz insists that disease must be based upon tangible pathology, that is unhistorical in my view because I think it is quite clear that diseases were diagnosed many years before pathology even existed. You know, Hippocrates diagnosed consumption, he didn't know what it was doing to him, he didn't know anything about the lungs, he just said that there are certain things that obviously this person can't do the ordinary things they can't breathe well, they aren't active, they've gotten sick, something has gone wrong. Do you feel that's an illegitimate description of a disease, that something has gone wrong?

SZASZ: I think that has nothing to do with the debate here, we're going to talk about Hipocrates now?

KLEIN: I'm sorry we're talking about the definition of disease.

SZASZ: Correct, we are talking about the definition of disease, then just like in modern physics you don't talk about some ancient Greek, you talk about the currently accepted definition of disease, which is the ability basically, why do we have CAT scans, why do

we have PET scans, why do we have chemical analysis of the blood, so we can make diagnosis scientifically, objectively.

KLEIN: Of what has gone wrong?

SZASZ: Of what has gone wrong, and as soon as diagnose something objectively as Dr. Leifer said it would be a brain disease, they all believe in diseases of the brain, we do not believe in diseases of the mind which by definition are metaphoric disease, now you don't want to make this distinction, psychiatry stands or falls, on confusing metaphoric with literal diseases, that is the mandate of psychiatry, and as soon as a mental disease becomes defined as brain disease it drops out of psychiatry and becomes neurology.

MODERATOR: Dr. Szasz, your turn for questioning.

SZASZ: Well, I would like to question Dr. Klein on the issue of what justifies locking up people. Because let's not forget before this program is over, you all like words don't mean anything, anything is a disease. In this century, six million Jews were killed, because they were a pathological organism. The holocaust was based on medical killing this is well established. It was manned by psychiatrists, originally. All German mental patients were killed by psychiatrists. Psychiatry will not confront its history. Forty thousand American veterans were lobotomized against their will, now what is your answer to that?

KLEIN: It seems to me that you have an answer, no matter what the question is, and it's the same answer.

SZASZ: No, it's a question.

KLEIN: You have the same answer. The question is depression a disease, and we're talking Auschwitz.

SZASZ: But I asked the question, American lobotomy, Rosemary Kennedy.

KLEIN: You're saying that there have been mistakes made.

SZASZ: They are not mistakes, in my opinion, what you call mistake is the essence of psychiatry, the control of human beings.

KLEIN: What gives you the right to that opinion?

SZASZ: I don't have a right to an opinion?

KLEIN: Yes, of course you have the right to your opinion.

SZASZ: I ask you, what is my right?

KLEIN: But if one has an opinion, one hopes that one will logically justify that opinion, rather than saying "That's my opinion."

SZASZ: Look at the history of psychiatry . . .

KLEIN: How is that the essence of psychiatry?

SZASZ: Look at going down the street here, people are locked up in mental hospitals here in New York City!

KRAMER: You won't talk about Hippocrates, but you are going to fifty years ago?

SZASZ: No, people are not locked up right now? Today, people are locked up today. John Hinckley is not locked up in the disguise of treatment?

KLEIN: You're saying they should be locked up as a criminal

SZAZS: No he should be executed, he tried to kill the president

KLEIN: I see.

SZASZ: I believe in law enforcement, I believe in leaving innocent people alone and punishing guilty people, you don't believe in any of that. You believe in the insanity defense.

KLEIN: I do believe you are criminalizing the ill. That's true. I do believe that. I believe you are criminalizing the ill; people who are sick, are not responsible for their acts. You're saying, take them out and shoot them.

SZASZ: One point.

MODERATOR: Let's move on. You can do it during your concluding statement. Dr. Goodwin, Dr. Schaler, first question Dr. Goodwin.

GOODWIN: I think that Dr. Szasz said something very important, that we don't believe in diseases of the mind. And I want to ask you if you agree with that?

SCHALER: Yes.

GOODWIN: OK. Now that we've discovered that there are diseases of the mind such as Alzheimer's.

SCHALER: We've not discovered that these are diseases of the mind.

GOODWIN: Is Alzheimer's disease a disease?

SCHALER: It is a disease of the brain.

GOODWIN: OK, and does it affect mental function?

SCHALER: Yes.

GOODWIN: Does it affect feeling, does it affect memory?

SCHALER: Any number of disorders can affect functioning just like when you take alcohol or marijuana and that affects functioning.

GOODWIN: Answer me, what makes Alzheimer's a disease and severe depression or manic depression illness not?

SCHALER: The discovery and identification of specific lesions in the brain at autopsy.

GOODWIN: So, something becomes a disease when people die and get that discovered?

SCHALER: That's the criteria that pathologists use.

GOODWIN: But what happens when that doctor had to diagnose my mother before she died?

SCHALER: What about it?

GOODWIN: Well, was he making a mistake to say this is Alzheimer's disease?

SCHALER: He may very well have made a mistake, she may have had multi-infarct dementia, she may have had a tumor, she may have had a number of problems.

GOODWIN: Ok, and how do doctors differentiate those things?

SCHALER: Through the basis of tests.

GOODWIN: Yeah, and don't they take a history and see whether the person . . .

SCHALER: But we rely primarily on signs, objective symptoms called signs. That's the criteria, that's not my criteria, that's pathologists' criteria.

GOODWIN: But I mean I make differential diagnoses every day, that's part of my business.

SCHALER: But you're a psychiatrist, you're not a real doctor.

GOODWIN: You're not even a psychiatrist; you're less than a psychiatrist.

SCHALER: That's right, I'm a psychologist. I know about behavior.

GOODWIN: No, but the point is, when I make a differential diagnosis, I want to take a history, I want to see what this person has had in the past. Do they have a history of vascular problems? Do they have a family history of vascular problems? Or do they have a family history of Alzheimer's disease? But basically the Alzheimer's disease has the same broad cluster of problems of thinking and feeling and acting as depression does.

MODERATOR: Time is up, Dr. Schaler; you can begin your questioning now.

SCHALER: Dr. Goodwin, don't you think that most people today have good reason to feel depressed because of what is going on in the world. I mean, listen to the news, the most popular movie of all time, bestsellers, what the titles are in the video stores?

GOODWIN: I agree with you, and the point I can use toward "feel depressed", most people have reason to feel depressed from time to time, most people don't have reason to be depressed. Being depressed is a clinical syndrome, and in effect the prevalence of depression goes down in wartime, I mean, it isn't vanishing. In a time when people should feel more depressed in an existential way, the actual prevalence of clinical depression actually goes down.

SCHALER: Actually there's a good explanation for that they are expressing their anger. They have a purpose and they express their anger.

GOODWIN: My point is simply in response to your question. There's a big distinction between overall unhappiness, overall depressed angst, or kind of societal angst that cultures go through at different times and clinical depression. Now look, clinical depression is clearly affected by the psychosocial environment. We've seen a doubling of the depression rate . . .

SCHALER: But do you think that there's no reason for people to feel depressed based on their experience of the world today? Can we just reflect philosophically? I mean, you seem to like to do that, right?

GOODWIN: I'm trying to get you to make the distinction . . .

SCHALER: I will not define the person by depression. No, I know what you're trying to do, I mean, do you call the person a cancer?

GOODWIN: Could you make the distinction between "little d" depression and "big D" depression?

SCHALER: No . . .

GOODWIN: Well, then . . .

SCHALER: . . . Because I look at it as an activity, it is an activity and a behavior.

GOODWIN: But my patients make that distinction all the time. Let me tell you this . . .

SCHALER: They make the distinction between activity and disease?

GOODWIN: My patients know very clearly the difference between their depression, their clinical "big D" depression and their angst.

SCHALER: Because you have brainwashed them into thinking that.

GOODWIN: No, they tell me.

MODERATOR: That's the end. Dr. Kramer, Dr. Leifer. Dr. Kramer, you can start questioning first.

KRAMER: Hi, Dr. Leifer, I think I understand you better as a result of the debate. You are someone who is willing to maintain a charade in the service of a good cause, which is you want to be able to sure that your patients are able to speak to someone, and speak about their hopelessness and so on. The basis of this debate I think has been physiochemical functioning, and I wonder if you presented some tracings of sleep EEG's to a physician and he said I can tell you on the basis of this person's sleep patterns, suppression of REM and so on, that this person is very likely depressed, what do you make of those sorts of correlations between physiological events and mood stance?

LEIFER: When our happiness project fail, and are dashed, we experience anxiety, because, anxiety is the fear of future danger, future danger for us is that things are not going to work out, when we're afraid, when we have the feeling that things are not going to work out, it's experienced as a threat to the organism. The response is a fight-flight response, part of which is anxiety-fear. People don't sleep when they are afraid. I call insomnia nocturnal hyper-vigilance, because when somebody is anxious, they remain vigilant looking for a danger which exists in the future. Which is part of the stupidity about depression-you say it doesn't have a moral quality. To me depression is a moral disorder or a malaise, I wouldn't call it a medical disease, it's a spiritual disease.

KRAMER: You're an old man. You're taking a syndrome that has been recognized since the time of Hipocrates that's all grouped together and you're re-labeling each portion so that the insomnia of depression is now nocturnal hyper-vigilance in the service of hopelessness, and so on.

LEIFER: Yes.

KRAMER: Well, that's a wonderful position to be in.

LEIFER: Thank you very much, so you concede defeat.

KRAMER: No, I can see that you are doing the absurd . . .

LEIFER: Simply because it's unconventional?

KRAMER: Well, yes, because I think there's no need to re-label . . .

LEIFER: For thirty years you have been silencing us, and not giving us the . . .

KRAMER: *I* have been silencing you?

LEIFER: Yes, you as representatives of the Psychiatric Profession.

KRAMER: I have been the subtle person who walks both sides of the line; I welcome both sides of the debate . . .

SCHALER: That's called hypocrisy.

KRAMER: That's called a relationship to hypocrisy.

LEIFER: We have not had the opportunity to present to the public our point of view on depression. Our stuff will not be published in psychiatric journals, I cannot speak-I was fired from . . .

MODERATOR: Dr. Leifer, you can question now.

LEIFER: Aha, so, main question, you say the basis of this debate is the physiological patterns in depression. I would like an answer to my question-how do you tell if they are cause or effect? To me they are effect.

KRAMER: Let me say the previous thing, which is I think you have proven that your position is not medical; you have not proven that depression is not a medical illness.

LEIFER: But it is a designation. If we all agree that it is, it will be called that. But I am protesting that.

KRAMER: Let me answer this question, which I'm supposed to not be able to answer, which is to say of course feelings and their physiological correlates are both cause and effect. I suspect that we are actually fairly similar in the end in how we view the phenomena. That is I think people are on a biological basis temperamentally more vulnerable to depression, some more than others, that the same degree of stimulus make some people depressed and it doesn't bother other people at all. And that when depression gets past a certain point, it becomes a disease, it has stable physiological correlates, it's part of a complex syndrome whose many facets have been recognized for many years, it is responsive to standard medical treatments, and the only reason we are having this debate is not that we disagree about these points, not that we disagree whether depression is an illness, but a political basis. That is, we disagree about the next step,

which is whether people who are ever severely mentally ill enter into the political realm in some way. That's the only debate at this point. I don't think there is a principled rational position anymore that says that severe depression is not a medical illness, comparable certainly to things like multiple sclerosis, osteoarthritis, and so on from which the full physiology has not yet been worked out.

LEIFER: What you are expressing is the hope that someday it will be worked out. I've been in the scene for forty years, hoping. When are you guys going to give up? You haven't found anything yet!

KRAMER: When are you going to concede?

LEIFER: When you find brain tissue which causes depression, which you have not found yet, and you still have not answered my question.

KRAMER: I will. Can you pose your question?

LEIFER: I will pose my question-Somebody comes into my office and they say I have a biochemical disorder . . .

MODERATOR: We're going to have to move on, we're running out of time. Dr. Szasz, your concluding statement.

SZASZ: Well, I am afraid that what happened is that we were like ships, like the proverbial ships passing in the night, to a large extent. So let me restate what I think is our joint position, certainly mine, and I think ours. We are interested in personal responsibility and personal freedom, first of all. And the issue of whether or not this is politics is good because everything we do is political and ethical including being sick and how we attend to it. And secondly, I would want to say this, the whole discussion that you essentially mount, constantly hinges on how you make people feel better. But let me just remind people of two historical things, one is that Sigmund Freud, described himself as over much of his life as being depressed and the only cure he found was smoking, you all know this is true. OK. So that doesn't prove it's an illness.

MODERATOR: Dr. Klein, your concluding statement.

KLEIN: I think I agree with Peter Kramer that we really were not arguing whether depression is a disease or not we are arguing about the limits on people's autonomy. And that one of the more difficult situations we have is when there are two positive goals, and two positive goals are respecting people's autonomy and also being benevolent to people that require help and at times cannot be autonomous. Dr. Szasz, I believe, takes the stand that one is autonomous no matter what. And I think that conflicts with a doctor's point of view that people can be limited in their cognition, in their ability to get along, in their ability to take care of themselves, at that point benevolent, if necessary paternalistic intervention is necessary. I think that is what the fight has been about. That the

argument has been disease means that you're not autonomous, and one must be autonomous, I'm afraid we're not always autonomous.

MODERATOR: Thank you, that ends this week's television debate. Next week a new debate. But this debate continues on our website, www.debatesdebates.com

END