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## **Comments**

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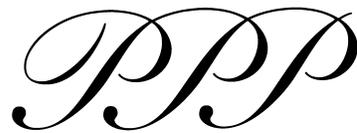
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# ON THE EVOLUTION OF DEPRESSION

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MIKE W. MARTIN



KEYWORDS: Depression, morality, mental disorders, psychobiology, evolutionary psychiatry.

IN “DEPRESSION AS A MIND–BODY PROBLEM,” Walter Glannon outlines a psychosocial-physiological explanation of depression as a psychological response to chronic stress—today, especially social stress—in which cortisol imbalances disrupt neurotransmitters. Accordingly, treatment for depression should combine psychopharmacology and psychotherapy—a valuable reminder in light of the current restrictions on funding for health care (Hobson and Leonard 2001). My comments focus, however, on Glannon’s objections to evolutionary theorists who explain our capacity for depression as adaptive to the natural and social environment. His objections are implausible because he fails to distinguish depression as a mood and a disorder.

## WHAT IS DEPRESSION?

Explaining the psychology, sociology, physiology, and evolution of depression presupposes knowing what depression is and hence what is being explained. As a blunt but important distinction, let us contrast depression as a mood and as a mood disorder.

As a *mood*, depression is a state of low spirits, typically involving painful and low affect (of a kind needing further specification). Not all negative low moods are depressions. It is notoriously

difficult to distinguish depression from grief, sadness, gloom, and a host of additional ways to feel down—especially because today many people use “I’m depressed” as a blanket expression for virtually any low mood. For the purposes of this paper, it is not necessary to attempt a full-blown analysis of depressed moods (and emotions). I would emphasize, however, that depressed moods involve values. They involve negative evaluations of ourselves, major events in our lives, life in its entirety, or the values that have been guiding us. Typically, to be depressed is to experience such things as feelings of worthlessness, dejection about failures, despair and hopelessness, and loss of caring and commitment. Thus, we might be sad or grieving but not depressed because we retain a solid grip on what is valuable and worthwhile. In any case, there should be no general presumption that depressed moods are all bad or undesirable. Instead, we should be prepared to appreciate the importance of depressed moods in connection with questions of value, identity, and even moral insight (Martin 2000). Depressed persons are not necessarily sick.

In contrast, depression as a *mood disorder* is, by definition, pathologic. Moreover, usually it is not a depressed mood, although it involves depressed moods. On the one hand, depression as a disorder is defined as pathologic, a notion that is itself understood in terms of values—the values of health and, indirectly, moral values that define what is culturally acceptable. Thus, even severe

grief can be nonpathologic, even though it involves depressed moods, when it is within the range of “culturally-sanctioned responses” (APA 2000, xxxi). On the other hand, only sometimes is depression a single pathologic mood, as in major depressive episodes that can strike with a terrifying and suicidal severity (APA 2000, 375). Usually, however, the pathology is not a single depressed mood, but instead a longer-term state involving recurring depressed moods and additional features, such as poor concentration, insomnia, poor appetite or overeating, and so on. For some purposes, such as research funding and billing insurance companies and government health providers, these pathologies can be equated with what is currently in the DSM. Yet, there are many additional states of suboptimal health, in which the DSM criteria are only partly met.

What does Glannon mean by depression? He does not define it, but he makes it perfectly clear that he intends depression as a disorder. Or rather, it is a set of mental disorders, including the “depressive disorders” of major depressive disorder, dysthymic disorder, depressive disorder not otherwise specified, and a variety of bipolar disorders and some anxiety disorders. Glannon sometimes indicates his primary topic is “severe depression,” which of course is not a DSM category (nor always a mark of pathology). For the most part, however, he says his topic is “chronic depression,” which might suggest dysthymia, “a chronically depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years” (APA 2000, 380). I suspect, however, that Glannon intends something broader than dysthymia, perhaps including most pathologic states that significantly involve depression that is severe and recurrent. Such a broader conception would allow him to bypass the vagaries of the DSM classifications, which fluctuate as its editions change. Nevertheless, he seems to target disorders that involve primarily depressed moods, rather than bipolar disorders, and he explicitly sets aside posttraumatic stress disorder. In any case, because parts of his paper are concerned with the physiology of depression, it might be helpful to more fully specify the disorders being explained.

My main concern, however, lies elsewhere. In a brief section titled “An Adaptive Response?” Glannon calls for a sweeping rejection of explanations developed by evolutionary psychiatrists and psychobiologists to explain why we have evolved as creatures who suffer depression (and lots of it). According to these evolution theorists, depression serves various adaptive purposes. Glannon argues that these theorists are mistaken because depression is a set of maladaptive disorders: “depression is an adaptive disorder consisting in an individual’s inability to adjust to the social environment. It is not a defense mechanism serving an adaptive purpose for the survival of the organism.” In making this claim, he assumes that the evolution theorists mean what he means by depression—namely, mental disorders. Do they?

#### MALADAPTIVE DISORDERS VERSUS ADAPTIVE DEFENSES

Are the evolutionary theorists trying to explain (a) the evolutionary purposes of depressed moods (both healthy and unhealthy ones) or (b) the evolutionary purposes of depression as a mood disorder only? Glannon assumes (b), but (a) is closer to the truth. I say *closer to the truth* because evolutionary psychiatrists also sometimes fail to distinguish (a) and (b). Even so, Glannon fails to engage the evolutionary theorists on their own terms, and sometimes he seems to attack a straw man.

As an example of someone who clearly intends (a) rather than (b), consider Randolph M. Neese’s “Is depression an adaptation?” (2000), an essay that Glannon explicitly targets. After noting the unclarity about what depression means, Neese stipulates that for his purposes “*depression* will refer to severe states of negative affect that are often but not necessarily pathologic, and *low mood* will refer to states in the common range of normal experience” (Neese 2000, 15). He notes the intuitive starting point that much low mood and depression are normal and become pathologic only in some forms and under some conditions. Then he seeks an explanation of both depression and low mood, concluding that although many depressions are pathologic (maladaptive), many other depressions and low

moods are adaptive in helping us deal with defeat and danger.

It seems likely that low mood and related negative affects were shaped to help organisms cope with unpropitious situations. Some negative and passive aspects of depression may be useful because they inhibit dangerous or wasteful actions in situations characterized by committed pursuit of an unreachable goal, temptations to challenge authority, insufficient internal reserves to allow action without damage, or lack of a viable life strategy (Neese 2000, 18).

In *Evolutionary Psychiatry*, another work targeted by Glannon, Anthony Stevens and John Price (2000) give credence to “attachment theory explanations” of depression, as well as to Neese’s escape-and-avoidance theory that focuses on competition and rank conflicts. Attachment theory emphasizes that love and other deep bonds of affection involve (as one mark of “depth”) grief, sadness, guilt, shame, and other forms of distress when the love is lost or threatened. These emotions can easily degrade into pathologic states. Stevens and Price are less careful than Neese in defining *depression*, but it is clear they are explaining a wider range of low-mood states and then subsuming pathology as a maladaptive distortion. Depressive disorders, they tell us, are best “understood as chronic exaggerations of innate behavioural potentials with which all human beings are equipped by virtue of their humanity” (2000, 48).

Glannon is not accurate, then, when he says, *tout court*, that evolutionary theorists portray and explain pathologic depression as adaptive. The theorists are not saying there is pathology in every depressed-mood withdrawal from competition and response to the loss of love. Instead, the theorists are explaining how humans came to possess general capacities for depressed moods that enter into a continuum from adaptive to maladaptive. These general types of explanations have great interest and promise, in my view, and Glannon provides no reason to reject them. Stated more positively, Glannon’s psychobiologic explanation of depression as a disorder is compatible with the work of the evolutionary theorists.

To confuse (or clarify?) matters further, let me suggest that evolutionary psychiatrists often interweave two different types of explanation of mood disorders, what I will call adaptive-sickness explanations and malfunctioning-defense explanations. *Adaptive-sickness explanations* explain why mood disorders sometimes serve purposes beneficial to individuals and groups. These explanations seem paradoxical, because by definition disorders are maladaptive or dysfunctional. In fact, the paradox is superficial. A disorder can be maladaptive in some ways (indicated in its defining criteria) and adaptive in other ways (given serendipitous circumstances). It is commonplace, but interesting, that maladies of many kinds can have good side effects (Sandblom 1995). For example, the maladies that take away a writer’s ability to walk might provoke the writer into greater commitment and concentration that result in an explosion of creativity (Price 1995). Similarly, it is amply documented that mood disorders sometimes play creative roles in the lives of artists (e.g., Lord Byron), leaders (e.g., Abraham Lincoln), and others (Jamison 1993).

*Malfunctioning-defense explanations* seek to explain a broader category of moods (or other mental states) as frequently adaptive psychological defenses against stress and anxiety, and then they portray mood disorders as breakdowns or distortions of those defenses. That is, they do not portray pathologies as adaptive; on the contrary, the disorders are maladaptive perversions of processes and states that normally function adaptively. Glannon, too, provides explanations of this sort. (In doing so, I might add, he distinguishes *psychological defense mechanisms*, which he says help us to avoid harm and social realities, and *disorders*. Yet, defense mechanisms, the idea introduced by Freud and refined by neo-Freudians, can serve healthy or unhealthy purposes.)

#### ONE CHEER FOR DEPRESSION

Clarity about definitions and distinctions, I have suggested, is essential in gaining clarity about what is being explained and assessed in evolutionary psychiatry and psychobiology. It is also important in connection with therapy and self-

understanding, in determining what is unhealthy or not, and in understanding the continuum between health, suboptimal health, and full-blown disorders. Indeed, our choice of terminology already reflects our attitudes. If we think of negative low moods as inherently undesirable then we will tend to use the word *depression* to connote sickness. If we discern value in many negative low moods we will be more likely to use the word *depression* to refer to a broad range of moods, most of which are normal and some of which are pathologic (Neese 2000, 15).

Furthermore, if we view all depressed moods as bad, we will have to usurp some other term to connote the wider range of healthy emotions. For example, Lewis Wolpert (1999) stipulates that (all) depression is pathologic and then uses *sadness* for wider range of emotions: depression is *malignant sadness*. For reasons I gave earlier, I think we should keep the broader sense of *depression*, and not equate depressed moods with sadness. No doubt that reflects both my attitudes and my idiolect.

Historically, attitudes toward depression (melancholy, acedia, etc.) have varied greatly (Radden 2000). At one extreme, much everyday depression is defended and even celebrated, a view associated with Romanticism. (I still remember that in an undergraduate course on English Romanticism I was graded down for failing to appreciate how much the Romantics value states that today we pathologize.) Some philosophers continue that positive emphasis on the desirable aspects of depression as part of a value-guided life (Solomon 1976). At the other extreme are the pathologizers, not just some Prozac-profligate psychiatrists but also many up-beat Americans who require steady and ever-increasing states of augmented cheerfulness to get through the week. In between are a variety of nuanced attitudes, including Susanna Kaysen's (2001) aptly expressed realism in giving "one cheer for melancholy" as unpleasant but often useful.

Evolutionary explanations of depression blur over most of the nuanced roles of depression in individual lives and cultures. Their broad-brushed explanations focus on only one value, however important: survival. Evolutionary theory is tele-

scopic: it observes big and complicated terrain from a great distance. In contrast, physiology is microscopic: it sees big and complicated terrain from close up. Telescopes and microscopes reveal much, but they also neglect much that is important in appreciating the nuances of the value-permeated world of human beings. Worse, they carry the danger of reducing complex value dimensions of human life to something simpler—a danger to which sociobiology fell prey (Midgley 1995).

Glannon's interest is mental health, but even our conceptions of mental health are immersed in a broader set of values than survival—values about morality and meaningful life. Furthermore, many psychologists have come to appreciate the need for focusing not only on disorders and threats to survival, but also on positive conceptions of health as well-being beyond the mere absence of disease (Snyder and Lopez 2002). I suspect that psychologists' current explorations in positive health will yield new insights into the positive contributions of depressed moods to meaningful life. In any case, depression as a mood raises important questions about moral values at several junctures: the value judgments internal to the mood (e.g., self- or world-denigration); the values under assault by the mood (e.g., loss of caring); defining the line (blurry) line between healthy moods and depressive disorders; therapeutic judgments about the best course of treatment for depressive disorders and suboptimal health.

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