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## *A Bad Case of the Flu?*

### *The Comparative Phenomenology of Depression and Somatic Illness*

**Abstract:** *This paper argues that the DSM diagnostic category ‘major depression’ is so permissive that it fails to distinguish the phenomenology of depression from a general ‘feeling of being ill’ that is associated with a range of somatic illnesses. We start by emphasizing that altered bodily experience is a conspicuous and commonplace symptom of depression. We add that the experience of somatic illness is not exclusively bodily; it can involve more pervasive experiential changes that are not dissimilar to those associated with depression. Then we consider some recent work on inflammation and depression, which suggests that the experience of depression and the ‘feeling of being ill’ are, in some cases at least, much the same (thus calling into question a more general distinction between psychiatric and somatic illness). However, we add that the phenomenology of depression is heterogeneous and that many cases involve additional or different symptoms. We conclude that ‘major depression’ is a placeholder for a range of different experiences, which are almost certainly aetiologically diverse too.*

**Keywords:** Bodily experience; depression; inflammation; phenomenology; somatic illness.

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## 1. Introduction

Clear phenomenological boundaries between broad categories of *psychiatric* illness — such as ‘depression’ and ‘schizophrenia’ — may be difficult to draw, but surely it is safe to assume that depression is distinct from experiences of *somatic* illness? In this paper, we suggest not. First of all, we draw upon a body of first-person testimony in order to emphasize that depression, as experienced by sufferers, is very much a *bodily* condition. Although it is not exclusively bodily, we argue that the same applies to experiences of somatic illness. Then we turn to recent scientific work on the relationship between depression and inflammation, which suggests that depression and bodily infection can be associated with similar neurobiological changes in brain areas connected with the regulation of mood, caused in both cases by increased levels of pro-inflammatory cytokines. Of course, it could be argued that, even if bodily experience in depression has much in common with certain forms of somatic illness (both phenomenologically and neurobiologically), depression has additional features. However, established diagnostic criteria are so broad that they encompass a heterogeneous range of experiences. Symptoms that are largely or wholly attributable to inflammation could, we suggest, meet the DSM-IV criteria for a major depressive episode. Hence some cases of ‘depression’ may well be phenomenologically indistinguishable from what we would expect to find in a case of undiagnosed infection by some pathogen. In certain other cases, differences may be symptomatic of greater duration of symptoms in depression and/or changes in self-interpretation and social relations associated with the diagnosis. However, different symptoms, which might well occur in the absence of inflammation, could equally meet the same diagnostic criteria. It is doubtful that this diverse phenomenology is united by a common aetiology. Hence, if the category ‘major depression’ is supposed to identify a unitary form of illness that can be reliably treated in a particular way, it is too broad to do the required work.<sup>1</sup>

## 2. The Bodily Phenomenology of Depression

It is often remarked that the expression or even experience of depression is cross-culturally variable. For instance, a ‘predominance of

[1] See also Ghaemi (2008) for the point that the concept of ‘major depression’ is ‘excessively broad’. Ghaemi argues from the limited efficacy of pharmaceutical intervention to the conclusion that treatment is guided by inadequate diagnostic categories: ‘since nosology precedes pharmacology, if we get the diagnosis wrong, treatment will be ineffective’ (*ibid.*, p. 965).

somatic symptoms' is evident in some non-western narratives of depression (Kleinman, 1988, p. 41). However, it is important not to understate the pervasiveness and salience of bodily symptoms in contemporary western depression narratives too. They are frequently emphasized in published autobiographies. For example:

Why do they call it a 'mental' illness? The pain isn't just in my head; it's everywhere, but mainly at my throat and in my heart. Perhaps my heart is broken. Is this what this is? My whole chest feels like it's being crushed. It's hard to breathe. (Brampton, 2008, p. 34)

Bodily symptoms are equally conspicuous in unpublished first-person accounts of depression. In 2011, we conducted an internet questionnaire study, which included the question 'how does your body feel when you're depressed?'<sup>2</sup> Out of 136 people who responded to that question, only two reported no bodily ailments, and two others were unsure. One or more of the words 'tired', 'heavy', 'lethargic', and 'exhausted' appeared in 96 of the other responses. Most of the remainder included comparable terms; there were complaints of lacking energy, feeling drained or fatigued, and having a sluggish or leaden body. In addition to the core themes of heaviness, exhaustion, and lack of vitality, people complained of many other bodily symptoms, including general aches and pains, headache, feelings of illness, sickness or nausea, joint pain, pain or pressure in the chest, numbness, and loss of appetite. Some also reported a sore throat and blocked nose. Responses varied in detail. Some consisted of only one or two sentences:

- #8. 'Very tired and uncomfortable.'
- #26. 'As heavy as lead. I can't drag it out of bed most of the time.'
- #41. 'Tired, aching.'
- #66. 'Tired and painful. I feel like gravity is pushing me down.'
- #129. 'My body seems very heavy and it's an effort to move.'
- #133. 'Exhausted, drained, no energy.'
- #180. 'Tired but not sleepy. Tight neck and shoulders giving headaches.'
- #266. 'Exhausted, heavy limbs, aching, headaches, tired, spaced out.'
- #312. 'Heavy, arched and with hot and cold sweats. Vulnerable and hollow.'
- #357. 'No energy. Just totally run down.'

Others were more detailed:

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[2] The questionnaire was posted on the website of the mental health charity SANE. Respondents identified themselves as depressed and, in most cases, offered details of their diagnoses. They provided free text responses with no word limit.

#14. 'Slow, heavy, lethargic and painful. Every morning I wake with a sore throat, headache and blocked nose. Everything feels 1000 times harder to do. To get out of bed, hold a cup of tea, it's all such an effort. My entire body aches and feels like it is going to break.'

#22. 'Lethargic, like it's full of lead. My legs felt heavy all the time and I felt ridiculously tired. It was a horrible cycle — the more I felt tired, the more I stayed in bed, so that when I did get up I'd feel even more lethargic. Sometimes I would feel so numb I felt like I couldn't eat anything, or I'd feel "too sad" to eat. I think a lot of people have this impression that depression is a purely mental illness, and I can't explain it but it totally affects you physically as well and your body just goes into meltdown mode.'<sup>3</sup>

Several respondents also reported negative evaluations of their bodies or some property of their bodies. These were mostly self-evaluations, although some also referred to how others saw them. The most frequent complaint was that of being 'fat' or 'ugly', the more general theme being disgust at one's body and often also oneself. Some also wrote that their bodies were 'pointless' or 'useless', where bodily uselessness was closely tied to uselessness of the self. However, in what follows, we will restrict our analysis to the core bodily symptoms that characterize almost every account, and will thus exclude — for current purposes — this dimension of body- and self-evaluation.<sup>4</sup>

On the basis of the testimony we have quoted, it might seem that bodily experience in depression is very similar to the kinds of experience associated with acute somatic illnesses such as influenza. However, perhaps they only *seem* similar because an exclusive emphasis upon bodily experience gives us a very partial picture of the phenomenology of depression. Depression also involves changes in emotion, thought, and volition, and in experiences of the world and other people. All of this is embedded in a more pervasive transformation of the person's experience of and relationship with the world (Ratcliffe, 2010b; in press). Sufferers often complain of finding themselves in an impoverished and alien realm, the nature of which they find very

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- [3] Respondents had various different diagnoses, but most of them stated their diagnosis as 'depression', 'clinical depression', or 'major depression'. Setting aside some cases involving mania and/or psychotic features, there was no discernable correlation between particular diagnoses and the kinds of description offered.
- [4] It is debatable whether and to what extent an attitude of disgust or shame directed at the body can be extricated from a more immediate bodily phenomenology. It is arguable that a sense of how others perceive one's body can be integral to everyday bodily experience, rather than being something that one has to infer from it (Sartre, 1989, Part 3; Ratcliffe and Broome, 2012). Perhaps one *feels* fat, ugly, or disgusting in a way that incorporates a sense of how one is perceived by others. On the other hand, it could be that one's body is judged to be disgusting or ugly on the basis of prior experiences and beliefs. It is difficult to discern which applies in any given case.

difficult to convey to others. The world is stripped of all the practical significance that it was once imbued with, and so they feel curiously detached from everything and everyone, not quite ‘there’. In addition, the kinds of significant possibility that things used to offer are sometimes replaced by a sense of inchoate threat. For example:

I awoke into a different world. It was as though all had changed while I slept: that I awoke not into normal consciousness but into a nightmare... At that time ordinary objects — chairs, tables and the like — possessed a frightening, menacing quality which is very hard to describe vividly in the way that I was then affected. It was as though I lived in some kind of hell, containing nothing from which I could obtain relief or comfort. (Testimony quoted by Rowe, 1978, pp. 269–70)

Many of our questionnaire respondents also reported profound changes in their sense of belonging to a world:

#17. ‘Often, the world feels as though it is a very long way away and that it takes an enormous amount of effort to engage with the world and your own life. It feels as though you’re watching life from a long distance. At times it felt as though I was looking through a fish eye lens, and couldn’t see clearly around the periphery, or even very well at all. I felt slightly pulled back from reality, as though there was cotton wool between my brain and my senses.’

#138. ‘I feel like I am watching the world around me and have no way of participating.’

Along with this, there were complaints of being imprisoned in a realm that offers no possibility of meaningful activity and no hope of escape:

#16. ‘It is as if I am being suffocated and I feel trapped with no escape apart from death...’

#28. ‘It [the world] feels pointless, there’s no future and no hope.’

#75. ‘When I’m depressed life never seems worth living. I can never think about how my life is different from when I’m not depressed. I think that my life will never change and that I will always be depressed.’

Hence one could maintain that it is ‘psychological’ changes like these, rather than associated ‘bodily’ experiences, that distinguish the phenomenology of depression from that of somatic illness. Furthermore, the bodily symptoms might be interpreted differently once their psychological context is acknowledged, further lessening the alleged similarity.

### 3. The World of Illness

On the basis of first-person testimonies, many somatic illnesses do appear to have an exclusively ‘bodily’ phenomenology. It is easy enough to find reports of experiences of influenza and other acute

illnesses. For example, a website on ‘cold and flu’ includes 153 first-person accounts.<sup>5</sup> They mention a range of symptoms, such as headache, sore throat, stomach ache, congested nose, throat, lungs, and/or sinuses, soreness, stiffness, aches, joint pain, feeling hot or cold, sweating, diarrhoea, watery and/or itchy eyes, weakness, and exhaustion. A few posts also complain of crying all the time and wondering when it will end. One person remarks, ‘I just want to die’, and goes on to say ‘this one makes me feel like absolute crap and I am just whinging and complaining and I just want to cry all the time’. But aside from that, the focus is almost entirely upon unpleasant bodily experience.

However, the few authors who explore the phenomenology of somatic illness in any detail tend to relate a more profound and encompassing change in how one finds oneself in the world. To quote Merleau-Ponty (1962, p. 107), illness can amount to a ‘complete form of existence’. Consider some remarks by Virginia Woolf, in her essay *On Being Ill*. First of all, Woolf emphasizes both the difficulty of describing our bodily experience and its neglect in literature: ‘English, which can express the thoughts of Hamlet and the tragedy of Lear, has no words for the shiver and the headache’ (Woolf, 1930/2002, p. 6).<sup>6</sup> She adds that the phenomenology of illness is not restricted to the body; it also transforms experience of the world and other people. Reflecting on being in bed with influenza, Woolf notes how ‘the world has changed its shape’; ‘the whole landscape of life lies remote and fair, like the shore seen from a ship far out at sea’ (Woolf, 1930/2002, p. 8). We find similar themes in J.H. van den Berg’s (1966) essay on the phenomenology of illness, *The Psychology of the Sickbed*. His emphasis is upon the experience of serious, chronic illness.<sup>7</sup> However, much of his discussion is equally intended to apply to more mundane cases of acute illness. Here too, a shift in how one finds oneself in the world is described. Along with altered bodily experience, the world looks different — familiar things seem somehow strange, distant. There is a sense of being dislodged from the realm of everyday activity: ‘I have ceased to belong; I have no part in it.’ The world has, van den Berg says, ‘shrunk to the size of my bedroom, or rather my bed’ (1966, p. 26). This shrinkage is attributable to one’s no longer being practically, purposively immersed in various

- [5] <http://coldflu.about.com/u/ua/flu/flusymptomsstories.htm> (accessed 11 Dec 2011).
- [6] Scarry (1985) makes a similar point about the experience of pain, claiming that it cannot be adequately expressed by language.
- [7] See also Carel (2008) for a detailed account of the first-person experience of serious, chronic illness, which emphasizes the extent to which illness changes one’s world.

projects that more usually determine whether and how worldly entities appear significant and solicit activity. A purposive striving towards the future that previously characterized experience and activity has been lost, and one therefore feels oddly rooted in the present. Things also become salient in new ways. How they appear is no longer constrained by their practical salience in the context of one's habitual concerns, and so all sorts of ordinarily overlooked details begin to show up:

The blankets of my bed, articles so much devoted to utility that they used to disappear behind the goal they served, so that in my normal condition I could not possibly have said what color they are, become jungles of colored threads in which my eye laboriously finds its way. (*Ibid.*, p. 29)

One's body is experienced in a new way too. What was taken for granted becomes conspicuous: 'The healthy person is allowed to be his body and he makes use of this right eagerly; he *is* his body. Illness disturbs this assimilation. Man's body becomes foreign to him' (*ibid.*, p. 66). In addition, van den Berg conveys the extent to which experience of body and world in illness are both regulated by relations with other people. Especially in cases of more serious, chronic illness, how the patient 'experiences his sickbed depends to a great extent on the behavior of the visitor: the way he enters, the way he finds a seat and the way he talks' (*ibid.*, p. 18).<sup>8</sup>

Why should a change in the overall way one's body is experienced be associated with an all-pervasive transformation of one's experienced relationship with the world? The answer, we suggest, is that bodily experience and world experience are inextricable. The phenomenology of the body is not restricted to its being an object of experience; it is also experienced as a medium of perception, that through which other things are perceived. This is a consistent theme in the phenomenological tradition. As Husserl (1989, p. 61) puts it, 'the Body [*Leib*] is, in the first place, *the medium of all perception*; it is the *organ of perception* and is *necessarily* involved in all perception'. Inspired by Husserl, Merleau-Ponty (1962, p. 146) adopts a similar but more elaborate account, according to which the body and its habitual dispositions and activities amount to 'our general medium for having a world'. Drawing on such work, Ratcliffe (2008) argues that terms such as 'bodily feeling' and 'bodily experience' are equivocal; a distinction needs to be made between the *feeling* body and the *felt*

[8] Elsewhere, van den Berg (1972) offers a phenomenological account of *psychiatric* illness, which emphasizes forms of experience that are remarkably similar (Ratcliffe, 2010a).

body, where the former is a medium through which something else is experienced, while the latter is an object of experience. It is thus a mistake to think of bodily experience as something that occurs in isolation from world experience; the two are often inseparable.<sup>9</sup> One might object that the ‘feeling body’ does not feature in experience at all, that the body is either a central/peripheral object of experience or disappears altogether from experience. Sartre (1989, p. 322), amongst others, leans towards such a view, in maintaining that when we are unthinkingly immersed in our projects, our bodily phenomenology amounts to no more than an organized system of practical possibilities sewn into the experienced world. However, it is more plausible, in our view, to retain a distinction between the feeling body and the phenomenologically absent body. A bodily feeling can be both an object of experience and — at the same time — a way in which something else is experienced. Indeed, it can be experienced *as* that through which something else is experienced (Ratcliffe, 2012).

We suggest that this general kind of approach is plausible when interpreting experiences of illness, including psychiatric illness. People with depression often try to express something that is neither an experience of the body in isolation from the world nor vice versa, but a way of experiencing both. For example:

Now, sitting in my pine-paneled room, I felt myself hurtling once more into the abyss. The mental pain was physical, as if the marrow of my bones were being ground into dust. (Thompson, 1995, p. 246)

Hence it is arguable that psychiatric illness can involve changes in bodily feeling that at the same time amount to alterations in ‘how one finds oneself in the world’ (Ratcliffe, 2008). For instance, Sass (2004) suggests that a loss of bodily affect in schizophrenia is bound up with what he calls ‘unworlding’, where the world appears stripped of practical potentialities. And Fuchs (2005) maintains that depression likewise has an essentially bodily phenomenology — it involves a process where aspects of bodily experience that usually operate as a medium for world experience instead become uncomfortably obtrusive, altering world experience in the process. Depression, he says, involves ‘reification or corporealization of the lived body’ (*ibid.*, p. 95). Thus the fatigue and discomfort described by most of our questionnaire

[9] Although Ratcliffe’s account of bodily feeling as world-involving draws explicitly upon work in the phenomenological tradition, others have made complementary points in different ways. For example, Goldie (2000; 2009) maintains that not all feelings are ‘bodily feelings’ with an exclusively bodily phenomenology. There are also, he says, ‘feelings towards’, where the phenomenology of the feeling is inseparable from its world-directed intentionality.



respondents also amounts to disruption of the body's role as a medium of experience and activity, and thus to a change in how they experience and relate to the world. For example, one person responded to our question about bodily experience with 'Tired — really, really tired — the stairs in my house seem like a mountain' (#147). The stairs are perceived in this way *through* the tired, cumbersome, incapable body. The kind of tiredness that people complain of is more extreme than mundane tiredness; it is the loss of an ordinarily taken for granted vitality that at the same time amounts to a draining away of practical possibilities from the experienced world (Ratcliffe, forthcoming). As Fuchs (2005, p. 99) puts it, there is a diminishment of 'the *connative dimension* of the body', of a sense of the world as an arena of variably enticing practical possibilities.

If somatic illness can similarly involve not just bodily experience but a change in how one 'finds oneself in the world', how are we to distinguish its phenomenology from that of psychiatric illness and, more specifically, depression? Of course, experience of serious, chronic illness is routinely distinguished from depression, as exemplified by the observation that depression is sometimes but not always co-morbid with it (National Collaborative Centre for Mental Health, 2010). Indeed, it is possible to have a general sense of well-being in the context of illness, something that is incompatible with a diagnosis of depression.<sup>10</sup> However, we want to focus on something more specific here. We are concerned with what distinguishes the phenomenology of depression from a certain kind of all-over bodily experience commonly associated with a wide range of illnesses, a general 'feeling of being unwell' that characterizes acute infections such as influenza as well as chronic illness, but need not be a *constant* accompaniment to the latter.

Now, nothing we have said so far is incompatible with the view that illnesses such as influenza involve an experience of the body, pure and simple. That some bodily experiences are inseparable from world experience does not rule out the possibility that others are principally

[10] Thanks to Havi Carel (personal communication) for drawing our attention to this. The possibility of well-being in illness shows that there is no simple correlation between the presence of disease, conceived of biologically, and a certain kind of experience. We are using the term 'illness experience' in a fairly permissive way here, to refer to kinds of experience that are attributable, at least in part, to the presence of some disease, kinds of experience that may turn out to be quite heterogeneous. Some of these experiences may arise in other contexts too, and so an 'illness experience' should be thought of as a kind of experience that is frequently rather than invariably associated with disease. When it comes to 'psychiatric illness', matters are more complicated still as it is often unclear what — if anything — the relevant disease process consists of.

or even exclusively of the body.<sup>11</sup> Perhaps what Woolf, van den Berg, and other phenomenologically inclined writers describe are exceptions to the rule. Should the view that certain somatic illness experiences are interestingly similar to depression therefore be dismissed? We suggest not. As Woolf points out, the phenomenology of somatic illness has been neglected, to the extent that we lack the language required to adequately convey it. But aren't influenza symptoms routinely and unproblematically described, as illustrated by the 153 accounts mentioned earlier? In fact, people seldom offer anything approximating a *description*. Instead, they *name* various phenomena and emphasize how unpleasant they are. Furthermore, a diagnosis of influenza gives one a disease entity and aetiology to refer to, along with an established canon of *bodily* complaints to list. In the case of depression, no disease process has been identified, and there is instead an emphasis on 'psychological' changes that many sufferers complain are difficult or even impossible to convey to others. Hence it is likely that a diagnosis of depression disposes one to emphasize symptoms that can be more easily circumvented when reporting an experience of influenza. It is also interesting to note that people with depression often report confusing its onset with that of influenza or some other infection. As one of our questionnaire respondent comments, 'It [the body] aches. I can feel fluish. My stomach and throat can ache and I feel anxious' (#228). Indeed, someone Ratcliffe spoke to at the time of writing this paper (who had suffered from depression once before) reported how he had recently thought he was becoming depressed and was very relieved when he then developed a cough and a runny nose. Hence the conclusion to be drawn at this stage is that we cannot rule out the possibility of differences between accounts of somatic illness and depression being largely attributable to established styles of report, rather than to marked phenomenological differences.

We will now consider some recent neurobiological evidence, which suggests that some cases of 'depression' are indeed phenomenologically indistinguishable from forms of experience that are, in other contexts, construed as symptoms of somatic illness.

#### 4. Depression, Inflammation, and the Feeling of Illness

It is easy to distinguish most cases of influenza from depression, as influenza involves more than just a vague feeling of being unwell.

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[11] For example, Goldie (2009) emphasizes that many feelings have world-directed intentionality but resists the view that they all do, maintaining that there are exclusively 'bodily' feelings too.

There are a range of more specific symptoms too, and the same applies to other illnesses. Indeed, one might argue that the ‘feeling of being unwell’ to which we refer is an abstraction from experience, rather than something that can be experienced in isolation and legitimately compared to depression. However, we reject that view, on the basis of both experience and immunobiology. What we have in mind is something that is often experienced before the onset of various more specific symptoms, which can also linger for a time after those symptoms have disappeared. It is not pathogen-specific; many acute and chronic illnesses are characterized by much the same kind of experience, which involves lack of vitality, inability to concentrate, diminished inclination to act, and a sense of being disconnected from things. The relevant experience is largely attributable to an immune response common to many illnesses, which involves the increased release of protein molecules called pro-inflammatory cytokines by white blood cells (particularly monocytes). These cytokines play a regulatory role, serving to increase the body’s inflammatory response to infection. It has long been recognized that inflammation in illness is correlated with behavioural changes (which have also been observed in animal studies) and with lowering of mood (Harrison *et al.*, 2009). Correlation does not add up to cause, but the view that pro-inflammatory cytokines are causally involved in feelings of lethargy and low mood is supported by experimental studies where inflammation is induced in healthy subjects (by injecting them with a vaccine, for example), and mood changes are monitored. Participants report or display symptoms such as ‘fatigue, psychomotor slowing, mild cognitive confusion, memory impairment, anxiety, and deterioration in mood’, which are strikingly similar to depression (*ibid.*, p. 2). Indeed, longer term inflammatory responses in patients treated with interferon (an artificial inflammatory cytokine) are associated with diagnoses of major depressive episodes in approximately 50% of cases. There is also a characteristic time course; lethargy and various other symptoms are more salient in the first few weeks, while anxiety and depressed mood become more pronounced after one to three months of treatment. The mechanism whereby pro-inflammatory cytokines induce sickness behaviour is not fully understood. However, it is accepted that they are able to act across the blood-brain barrier, and it seems that sickness-associated experiential changes owe much to their influence upon activity in specific areas of the brain, including some of those implicated in mood regulation.

Interestingly, depression is also — sometimes, at least — associated with heightened levels of inflammatory cytokines. Several

markers of inflammation are found in depressed patients, regardless of age of onset, severity, and type (Raison, Capuron and Miller, 2006; Miller, Maletic and Raison, 2009). This is perhaps unsurprising, as acute/chronic psychological stress also triggers increased release of inflammatory cytokines and episodes of depression are frequently preceded by stressors (Raison, Capuron and Miller, 2006; Miller, Maletic and Raison, 2009). It has therefore been suggested that depression is wholly or partly attributable to over-activation of the immune system: ‘depressive disorders might be best characterised as conditions of immune activation, especially hyperactivity of innate immune inflammatory responses’ (Raison, Capuron and Miller, 2006, p. 24). In support of this hypothesis, there are studies reporting that antidepressants in conjunction with anti-inflammatory drugs are more effective in treating depression than antidepressants alone (e.g. Müller *et al.*, 2006). And, as Raison, Capuron and Miller (2006) observe, the inflammation hypothesis of depression also helps to account for the increased prevalence of depression in medical illness (which they claim to be five- to tenfold), given the near ubiquity of inflammation in illness.

When it comes to determining whether and to what extent the phenomenology of depression is akin to that of a general ‘feeling of being unwell’, the neurobiology can help to arbitrate. Changes in brain activation associated with inflammation-induced mood changes were investigated by Harrison *et al.* (2009), who conducted an fMRI study monitoring brain activation in subjects who had been injected with typhoid vaccine (which causes an inflammatory response). They found that areas showing increased activation corresponded to those identified by Helen Mayberg and colleagues as centrally involved in depression, principally the subgenual cingulate (e.g. Mayberg, 2003; Mayberg *et al.*, 1999; 2005). These changes in brain activation were correlated with first-person reports of fatigue, low mood, anxiety, and other symptoms. Harrison *et al.* (2009, p. 2) thus propose that there is a ‘common pathophysiological basis for major depressive disorder and sickness-associated mood change and depression’.<sup>12</sup> We do not want to put too much weight upon neurobiological data. Nevertheless,

[12] It is also interesting to note that the same inflammatory cytokines (e.g. IL-6) have also been implicated in alcohol hangovers. Verster (2008) suggests that a hangover involves two largely independent factors: dehydration symptoms and the effects of increased concentrations of pro-inflammatory cytokines, although he adds that the picture is complicated by additional factors such as tiredness, food, smoking, and congeners (colourings and flavourings in drinks). Depression is sometimes compared to a bad hangover. For example, one of our questionnaire respondents describes it as a ‘permanent hangover’ in order to ‘illustrate the sense of everything closing in and the feeling of hopelessness’

we take the following methodological principle to be generally sound: where there *seems to be* no phenomenological difference between experiences of type A and type B, an absence of associated neurobiological difference supports the view that there is indeed no difference.

Where does this leave matters? In the remainder of this section we will critically reflect upon some of the conclusions that might be drawn. The most radical view would be that depression and a feeling of being ill are one and the same. Depression, it might be argued, is the kind of experience someone has when chronically inflamed. In support of this view, many of our questionnaire respondents emphasized a general feeling of being unwell that appears to be indistinguishable from the kind of experience typical of a range of illnesses (at least in the absence of further qualification):

#155. 'Tired, achy, unwell.'

#352. 'I notice small aches and pains more and also feel nauseous and have an indefinable feeling of being unwell.'

#334. 'When I first started to suffer from depression I always used to say that it felt as though something "wasn't quite right" in that I generally felt under the weather. It felt as though I was always coming down with a cold in that I felt "below par". My swings in mood are generally accompanied by headaches, sometimes quite bad, and I will always wake up with them. If that is the case I know that my mood is changing and that my headache will not go until I go to sleep that night.'

This view would cast doubt upon the legitimacy of 'depression' as an illness category. Given that forms of experience associated with influenza, tonsillitis, and a range of other infections are not categorized as 'depression' but as symptoms of infection by some pathogen, it would surely be dubious to insist that all those other inflammation experiences where the aetiology is unknown constitute a single medical condition. Of course, one could maintain that depression is not to be identified with its symptoms; it is instead what causes them. Radden (2009, pp. 79–80) makes the helpful distinction between an aetiological/causal conception of depression and an 'ontological descriptivism' that identifies depression with a cluster of symptoms. But to appeal to aetiology here would be to mortgage the integrity of the construct 'depression' upon future discovery of a common cause of all those phenomena currently falling under the category 'symptoms of inflammation not currently attributed to known pathogens'. And that would surely be wishful thinking. Depression is frequently associated

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(#60). Another says that it is 'like when you have just had a load to drink the night before and just woken up with a desire to stay put and sleep' (#242).

with some stressor, but there is a need to distinguish between proportionate and disproportionate reactions to events, and there are thus different kinds of causal story to be told about stressors, perhaps many different kinds.<sup>13</sup> In other cases, 'depression' might arise due to undiagnosed or as yet unidentified pathogens, or some other trigger of inflammation. So, even if all cases were principally attributable to inflammation, we would expect depression to be causally diverse. It is already well established that inflammation has a variety of causes and there are no grounds for thinking that cases of 'inflammation: cause unknown' are exceptions to the rule. Hence, if the radical view was the correct one, 'depression' would be best construed as a temporary placeholder, to be jettisoned once we have a more refined understanding of the different phenomena that it encompasses.

However, an obvious objection to the radical view is that symptoms such as low mood are not constant accompaniments to all instances of inflammation. Hence the phenomenology associated with inflammation does not add up to that of depression. One could respond to this by maintaining that the relevant phenomenology is a *common* symptom of inflammation, rather than a *universal* symptom. In those cases where that phenomenology is associated with infection by some pathogen, it is generally regarded as a symptom of somatic illness rather than depression. So the position would be that depression is indistinguishable from the kinds of experience associated with *some* inflammatory responses to infection, rather than every such response.

A further objection is that not all cases of illness that involve the general feeling of being unwell, which the radical view takes to be indistinguishable from depression, are co-morbid with depression. Therefore, depression must be different from the experience of inflammation. However, in cases where a somatic illness has already been diagnosed, the fact that symptoms *p*, *q*, and *r* can be attributed to that illness rather than depression need not imply a phenomenological difference between the two. In the absence of a diagnosed somatic illness, exactly the same symptoms might be attributed to depression instead, as exemplified by the DSM instruction to disregard what would otherwise be depression symptoms when they can be attributed to another medical condition (DSM-IV-TR, 2000, p. 351). Nevertheless, the possibility of co-morbidity still implies that at least some cases of 'depression' involve something more. Otherwise, depression

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[13] Horwitz and Wakefield (2007) observe that a proportionality criterion has been removed from the DSM classification system, so that it does not give us the means to distinguish an appropriate reaction to circumstances from an excessive reaction. Consequently, both get diagnosed as depression.

could not be diagnosed in conjunction with *any* of those inflammatory conditions that are themselves associated with an alteration in how one ‘finds oneself in the world’, and it frequently is. Indeed, one might argue that, contrary to the radical view, depression *always* involves something more, that a general feeling of sickness is common to depression and somatic illness but never sufficient for depression.

Where there are phenomenological differences between an instance of depression and a general feeling of being ill, it is arguable that at least some of them are attributable to duration of symptoms. As noted earlier, it has been proposed that the symptoms of inflammation follow a temporal pattern, with mood changes that lead to a diagnosis of major depression becoming more pronounced in the longer term. So perhaps the initial sickness feeling is not sufficient for depression but predisposes one towards other phenomenological changes that are. Maybe the kinds of inertia and despair associated with depression are only phenomenologically intelligible in the context of already having a body that is drained of its vitality and a world that is no longer alive with possibilities for bodily activity.<sup>14</sup> Alternatively, there could be a simple causal relation here. It is surely plausible to maintain that living with chronic illness *makes* some people depressed. And perhaps, in certain other cases, the illness causes physiological changes that lead to depression. A causal account of either kind would commit us to the view there is more to depression than an overall feeling of being unwell (regardless of how long one might be inflamed for). And it is quite clear that there can be. For example, depression symptoms such as despair do not relate in a systematic way to a prior experience of inflammation. Such feelings can take several different forms. One might lose hope in relation to a project that is central to one’s life and thus lose a whole system of long-term hopes and aspirations, or one might lose ‘hope’, in the deeper sense that one is unable to entertain the possibility of hoping for anything. In the latter case, ‘hope’, rather than a system of hopes, is gone from one’s world. And there are several variants of the latter — one might lose all sense of there being non-trivial hopes; one might lose all hope in the context of one’s own life but retain hope in relation to the lives of others; or one might live in a world where all hopes seem fragile, where all projects rest upon something that is uncertain, untrustworthy, and perhaps even malevolent (Ratcliffe, in press). Any one of these might be associated with a

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[14] A comparison could be drawn here with Sass’s (e.g. 2003) account of negative symptoms in schizophrenia, according to which later psychotic symptoms are only intelligible in the context of early symptoms such as affective changes and a draining of practical significance from the world.

diagnosis of depression. It is arguable that certain forms of despair are indeed closely associated with inflammation. Put crudely, bodily fatigue might eventually add up to a sense that one cannot do various things. So everything seems impossible and hope in one's ability to achieve anything is progressively eroded. However, it is far from clear that all instances of despair take that form. Indeed, there are surely 'existential' forms of despair that do not depend essentially upon feeling drained of bodily vitality.<sup>15</sup> To all this, we can add that there is a need for caution regarding the inflammation data. As Raison *et al.* concede, some studies have failed to find a correlation between inflammation and major depression. They thus acknowledge that 'strong pronouncements about the role of the immune system in depression might be premature'; inconsistent findings suggest that 'inflammation contributes to some, but not all, cases of depression' (Raison, Capuron and Miller, 2006, p. 25).<sup>16</sup> Furthermore, it is likely that the phenomenology associated with inflammation is itself variable, perhaps markedly so.

To further complicate matters, diagnosis can itself shape how a person experiences, interprets, and responds to her condition. Although people with influenza sometimes ask 'when will this end?', the time-scale is fairly predictable. Appreciation of one's predicament as longer term and of unknown duration might itself shape how it is experienced. Diagnosis of depression involves greater uncertainty, and the sense that 'this might never end' or 'this will never end' could surely precipitate or fuel feelings of despair.<sup>17</sup> In addition, depression can be interpreted by the sufferer in a way that differs from how somatic illnesses are generally conceived of. Influenza is a foreign invader that inflicts symptoms upon one from the outside, whereas many depression narratives construe depression as integral to the self. As Radden (2009, p. 16) puts it, accounts of depression often have a 'symptom-integrating structure', rather than one that sets the illness apart from the self. This interpretive tendency may partly account for the frequency of complaints of worthlessness, guilt, and inability in depression. Whereas influenza temporarily stops one from doing things that one is capable of doing or prevents one from acting in ways

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- [15] This difference may relate to the distinction between 'demoralization' and 'depression' drawn by Kissane and Clarke (2001) and Clarke and Kissane (2002).
- [16] Krishnadas and Cavanagh (2012, p. 495) suggest that only around a third of people with diagnoses of major depressive disorder have raised levels of inflammatory biomarkers.
- [17] With this in mind, and also the earlier observation that more severe depression symptoms may be associated with longer term inflammation, it would be interesting to explore the comparative phenomenology of longer term infections such as glandular fever (infectious mononucleosis), as well as that of chronic fatigue syndrome (myalgic encephalopathy).



that are consistent with who one takes oneself to be, depression is often taken by sufferers to be inextricable from who they are and what they are capable of. Much the same point applies to social relations. A person might feel socially uncomfortable or estranged from others due to an external constraint that gets in the way of her normal social dispositions, or she might construe herself as cut off from others due to an enduring attribute of herself. Thus it is arguable that certain symptoms of depression can be accounted for in terms of how one conceives of one's predicament, and that these are partly responsible for setting it apart from experiences of somatic illness. In addition, there are various social and interpersonal norms associated with diagnoses of depression and psychiatric illness more generally, which regulate the behaviour of friends, family, and clinicians, and might equally shape one's experience and behaviour.

### 5. The Heterogeneity of Depression

How do we arbitrate between the various options outlined above? In asking that question, we get to the heart of the problem. Current conceptions of depression, and also more specific subcategories such as 'major depression', are too permissive to facilitate the required distinctions. They accommodate and fail to distinguish a variety of predicaments, which are likely to differ from the phenomenology of somatic illness in different ways and to different degrees. Consider the DSM-IV-TR criteria for a major depressive episode:

[For at least two weeks] there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. (2000, p. 349)

The majority of these symptoms are implicitly or explicitly phenomenological, and they are all under-described. For example, 'depressed mood' can surely refer to a range of experiences. And consider feelings of guilt and worthlessness. It is possible to distinguish between several importantly different kinds of guilt feeling. One might feel guilty about something specific, or perhaps guilty about something that one finds hard to pin down. Alternatively, one might have a generalized feeling of guilt that encompasses many deeds. Another variant is where one feels that one *is guilty*, pure and simple; one's essence is

guilt, a guilt that does not attach to a specific set of deeds (Ratcliffe, 2010b). Any of these could feature in a depression narrative. So ‘guilt’ in depression, like ‘despair’, refers to a range of experiences. Given the phenomenologically permissive way in which depression is described by diagnostic systems such as DSM-IV and ICD-10 (WHO, 1992), the general feeling of being unwell, associated with illnesses such as influenza, does indeed meet the criteria for a major depressive episode, at least in those cases where another illness has not been diagnosed. It can certainly involve depressed mood and loss of interest in activity for at least two weeks, along with other symptoms including decreased energy, difficulty thinking, and changes in sleep patterns. And the neurobiological similarities further point to the view that there is no principled way of distinguishing between the two phenomenologically. That they share neural correlates suggests they are indeed what they seem to be: much the same. To add to the problem, a predicament that did not involve this general sickness feeling could equally meet those same criteria. One could surely lose interest in activity without having a general feeling of illness, and — depending on the circumstances — this might be associated with weight change, guilt, lack of concentration, and even thoughts of suicide. So it may well be that certain experiences of ‘major depression’ are only superficially similar. In the absence of a common phenomenology or aetiology that unites them and sets them apart from other forms of illness, it is not clear what does unite them, other than entrenched diagnostic practices.

What we have here is a dynamic and diverse phenomenology, which is associated with a range of causes, and embedded in systems of meaning that involve various norms of self-interpretation and performance. The radical conclusion that there is no difference between the phenomenology of depression and a chronic, pronounced feeling of sickness should therefore be rejected, not simply because ‘depression is something else’, but because depression is too untidy. The category ‘depression’ does accommodate ‘no difference’ cases, but it accommodates various other cases too. The literature on depression and inflammation tends to assume the legitimacy of the diagnostic category ‘major depression’. Indeed, Raison, Capuron and Miller (2006) even engage in some speculative evolutionary theorizing about how depression might involve an adapted immune response that has become maladaptive in modern social environments. Harrison *et al.* similarly accept the category ‘major depression’ and consider what the mechanisms underlying it might be: ‘neurobiological circuits supporting adaptive motivational reorientation during sickness might be

“hijacked” maladaptively during clinical depression’ (Harrison *et al.*, 2009, p. 9). However, the findings of such studies, when united with the kind of phenomenological reflection pursued here (which fails to discern a clear phenomenological difference), render that category highly problematic. It is based largely upon phenomenological considerations but encompasses a heterogeneous range of phenomena, whilst failing to distinguish them from other phenomena that it is not supposed to encompass. In addition, it gives us no basis for thinking that these phenomena are aetiologically united.

Further phenomenological and neurobiological research is needed in order to discern what, if anything, might distinguish the range of somatic illness experiences from the range of depression experiences. In the absence of the clarification and refinement that such research might bring, ‘depression’ risks being a ‘catch-all’ term. This raises serious concerns in relation to the treatment of depression. As the diagnosis accommodates many different experiences and causes, there is every reason to suspect that an effective treatment for one of them will not be an effective treatment for some or all of the others. That conclusion is consistent with recent literature reporting the limited, variable, and/or unpredictable efficacy of current antidepressant treatments.<sup>18</sup>

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[18] See, for example, Ghaemi (2008), Kirsch (2009), and Undurraga and Baldessarini (2012). Kirsch goes so far as to claim that antidepressants are no more than ‘active placebos’. However, if subtypes of what we currently call ‘major depression’ are better distinguished, we might find that they are effective for some types but not others. Hence reports of their limited effectiveness or even ineffectiveness could be partly attributable to an inadequate nosology, as Ghaemi (2008) suggests.

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