



**GOOD**

**MOOD**

**BAD**

**MOOD**

**HELP AND HOPE FOR DEPRESSION  
AND BIPOLAR DISORDER**

**CHARLES D. HODGES M.D.**

# GOOD MOOD, BAD MOOD

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AND BIPOLAR DISORDER

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Finally, as Paul wrote, I am what I am by the grace of God. I thank God for giving me the privilege of writing a book.

## Introduction: Please Read Me!

**W**hen I set out to write *Good Mood, Bad Mood*, I intended to write about bipolar disorder to explain the explosive increase in the numbers of people who receive this diagnosis. But as I did the research, it became obvious that there is more to the issue than just explaining bipolar disorder. I found that the way we diagnose and treat depression is at the heart of the problem.

To understand bipolar disorder, we must understand the changes that have occurred in the diagnosis of depression. As a result, this book begins there and moves to the discussion of bipolar disorder in the following way:

Chapters 1–3 deal with the way our society views depression and examine the difficulties with the way the diagnosis is currently made. It seems as if everyone involved in the care of depression agrees about its cause and cure, but my research revealed much disagreement in the field. That important disagreement has been documented in the many footnotes that accompany the text. These notes are extensive but I hope they will serve as a valuable resource as you consider the role of the diagnosis of depression in our society.

Chapters 4–5 examine the way sadness has been confused with depression. This has resulted in “sadness over loss” being changed

into the disease category of depression. This very significant change has been thoroughly documented as well. When sadness over losing things becomes a disease, it looks like an epidemic!

Chapters 6–13 examine the hope God gives us in his Word as we face struggles and sadness. Sorrow, anger, and worry are problems for which the Bible offers answers. We consider them in this part of the book primarily through a case study of one individual.

Finally, in chapters 14 and 15, we focus on bipolar disorder and the ways we can help those who have received this diagnosis. My hope is that this book will prove useful in clarifying the issues surrounding the diagnoses of depression and bipolar disorder and in presenting biblical ways to help those who suffer.

# 1

## Making Choices, Looking for Hope

**M**ost people do not enjoy being sick. I know there are a few who make a life's work out of their illnesses, but the rest of us could go a lifetime very happily without seeing a physician. I know this is true because I am a doctor. Most of my patients like me well enough, but they would rather run into me at church or the grocery store instead of my office. Some of them have medical problems that require them to come to my office several times a year and most of them do not look forward to it.

Usually, though, I can say that we help them. The medicine they take for their high blood pressure or diabetes makes a big difference in how long and how well they live. Unfortunately, it is not true for everyone. There are diseases we just don't have good answers for yet.

This has always been the case in medicine. Doctors are always looking for better cures. It was true when Jesus walked this earth. One case history illustrates the point. A woman had a problem that could not be cured with the technology and medication available at the time. Instead of having a simple monthly menstrual period, this woman had been hemorrhaging for twelve long years. Her



story appears in three gospel accounts and Luke gives us the facts from a physician's viewpoint.

And a woman who had a hemorrhage for twelve years, and could not be healed by anyone, came up behind Him [Jesus] and touched the fringe of His cloak, and immediately her hemorrhage stopped.

—Luke 8:43–44

It had to be hard for a doctor to write that no one could help her. The woman had been cared for by many physicians, and not a one of them had an answer for her disease. It is tempting to say that Dr. Luke has been amazingly transparent here—until you read Mark's account of the same event.

Doctors typically avoid saying bad things about other doctors, but Mark was not a doctor. He described her as “a woman who had had a hemorrhage for twelve years, and had endured much at the hands of many physicians, and had spent all that she had and was not helped at all, but rather had grown worse” (Mark 5:25–26). Ouch! That was my thought as I read this as a physician.

This poor woman had not just been failed by the medical profession; she had “endured” much suffering. On top of that, she had gone broke paying medical bills and still was worse off than when she started! Admittedly, medicine was very primitive then. There were few medicines that worked and many of them, like mercury and arsenic, were poison. There were no x-rays, lab tests, or ultrasounds, but still, I wish my ancient colleagues could have helped her.

Instead, this woman found the help that only God could give her. She touched the hem of Jesus' robe and her bleeding stopped. The disease that had plagued, impoverished, and crippled her life for twelve long years was cured in an instant by the God who created her.

### **A Modern Parallel**

Thankfully, medicine has made amazing advances since that woman was healed by Jesus. But we still face the same problem that doc-

tors did in Luke's day. We encounter diseases that we struggle to accurately diagnose and effectively treat. And patients endure much.

The purpose of this book is to look at another area of medicine in which patients face the kind of problems this woman faced. The diagnosis and treatment of the disease do not result in a rapid and complete cure. The cost of treatment and the lost wages are a significant burden to those affected. Yet in a significant number of cases, the real solution may be found in a meaningful encounter with the "Great Physician."

Mood disorders, including depression and bipolar disorder, have been at the center of health care in our country since the 1980s with the introduction of Prozac. We have spent billions of dollars to diagnose and cure depression, bipolar disorder, and related diseases. But the results are nearly as discouraging as they were with our first-century patient. The results for the diagnosis and treatment for mood disorders today are mixed.

Recent research would indicate that the current medical treatments do not seem to work well for many who are identified as depressed.<sup>1</sup> At the same time, there is concern that the way we make the diagnosis will apply the label of depressed to many who actually have emotional struggles but no disease.<sup>2</sup> There is also some indication that medicines may not be working as well as they did in the past.<sup>3</sup> Instead of finding a cause and cure for depression, we seem to be diagnosing more people with depression, but

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<sup>1</sup>Jay Fournier, Robert DeRubeis, Steven Holton, Steven Hollon et al. "Antidepressant Drug Effects and Depression Severity," *Journal of the American Medical Association* 2010;303, (1):51. This study indicated that true drug effect was "nonexistent to negligible" for individuals with mild, moderate, and even severe depression. Only in "very severe depression" was true drug effect seen as compared to placebo.

<sup>2</sup>Alan Horwitz, "Creating an Age of Depression: The Social Construction and Consequences of the Major Depression Diagnosis," *Society and Mental Health*, 2011, 1(1) 41–54. Horwitz concludes on page 51 that the rapid increase in the rate of depression was better explained by changes in the criteria used to make the diagnosis rather than an increase in the prevalence of the disease.

<sup>3</sup>N. A. Khin, Y. F. Chen, Y. Yang et al. "Exploratory analysis of efficacy data from major depressive disorder trials submitted to the U. S. Food and Drug Administration in support of new drug applications," *Journal of Clinical Psychiatry*, 2011 Apr; 72 (4) accessed at [www.ncbi.nlm.nih.gov/pubmed/21527123](http://www.ncbi.nlm.nih.gov/pubmed/21527123) (accessed on 4/20/2012). This article indicated that the effect of placebos in drug trials had increased in the years 1983–2008 while "treatment effect clearly decreased."

with questionable benefit<sup>4</sup> and significant side effects.<sup>5</sup> One of my patients illustrates these problems.

### **Susan's Story**

Susan<sup>6</sup> had begun to feel unwell nearly five years before she came to see me. She could not put her finger on what was bothering her at first, but she hurt in places she had never hurt before. She tried to ignore it but then worked her way through a succession of vitamins and glucosamine supplements. None of them seemed to help and, as a last resort, she decided to see her doctor.

Susan's family physician was a kind man with a good bedside manner. She did not run to the doctor for every ache and pain but, when she did go, Dr. Wilson always seemed to want to help. Usually a week's worth of some kind of medicine would have Susan back on track.

I wish I could say that Susan found the answer to her trouble during her first visit with Dr. Wilson. Instead she began a difficult search for relief from her pain. It began with blood tests, x-rays and ibuprofen that provided neither a diagnosis nor relief.

Dr. Wilson carefully worked through the likely causes of Susan's problems. After several visits Susan knew she did not have arthritis, lupus, ruptured spinal discs, hepatitis, chronic fatigue syndrome, or Lyme disease. The idea of fibromyalgia was entertained briefly, but she did not have enough of the specific tender points to meet the criteria. Like the man without a country, she moved from diagnosis to diagnosis for weeks.

After multiple visits, a pint or two worth of blood tests, and multiple MRIs, the defining moment of her life came in one of

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<sup>4</sup>Alan Horwitz, "Creating an Age of Depression," 49. From 1987 to 1997 "the proportion of the U. S. population receiving outpatient therapy for conditions called depression increased 300 percent."

<sup>5</sup>P. Andrews, J. A. Thomson, A. Amstader, M. Neale, "*Primum non nocere*: an evolutionary analysis of whether antidepressants do more harm than good," *Frontiers in Psychology*, April 2012:3(117) 1–19. This is an excellent review of the current literature on depression. The authors state, "The weight of the current evidence suggests that antidepressants are neither safe nor effective." They do not say they should not be used but maintain that these medications should be used less.

<sup>6</sup>To avoid revealing any individual's medical history, Susan is a composite of several patients.

her many office visits with Dr. Wilson. I think I know how that doctor felt and what he must have been thinking. He had done every test he knew, considered every reasonable diagnosis, and tried multiple medications without much success. There were just two options left and Susan would have to make a choice.

After his diligent workup, Dr. Wilson believed that Susan was depressed and her pain was the result of a chemical imbalance in her brain. As sincerely and as kindly as he could, the doctor suggested that Susan either see a specialist for another opinion or take a new antidepressant as a trial to see if the diagnosis was correct.

The medicine would be free because Dr. Wilson had samples provided by the drug company. He hoped that in two weeks she would be better. What was there to lose? After hundreds of dollars in co-pays, Susan did not want to start over with another doctor and more tests. For a moment Susan hesitated, weighing the options.

As Susan did the calculations, she knew that Dr. Wilson cared and was well informed. He must certainly be telling her the truth. The medicine trial would be free since the manufacturer was providing samples. It gave her hope to think that after all the time and tests, she had something that could be treated.

So Susan chose to take the samples and begin treatment. Almost immediately she began to feel better. Dr. Wilson must be right! If all went well, in six weeks her pain would be a distant memory. Unfortunately, things did not work out that way. After six weeks, Susan believed she was somewhat better, but she now was contending with a new set of symptoms.

She found herself restless, with a feeling that she could not sit still. A new sense of anxiety gripped her. She now worried about things for no good reason. Instead of simply being concerned about her health, she worried about everything. Sleep began to elude her and her family and friends began to notice that she seemed on edge a lot of the time.

This prompted a return visit to Dr. Wilson with Susan's husband along. He was concerned about the changes he was seeing in Susan. He wanted to know more about what the doctor thought was wrong.

Dr. Wilson listened attentively to Susan and her husband and admitted that he was puzzled by the outcome of her treatment. She seemed to be doing so well at her follow-up visit, but he noted that sometimes some medicines don't agree with some patients. He offered to switch to a different drug from the same class and gave Susan samples. This seemed reasonable to Susan and her husband and they headed out the door with drug number two.

Sadly, Susan returned two weeks later because now she was struggling to sleep. Dr. Wilson noted that the medication could cause sleep disturbances. He offered to add a second drug at bedtime that would help. Now Susan was taking two antidepressants without feeling a great deal better than she did before the process started.

Six weeks later Susan returned, feeling much as she had on her previous visit. This time she came armed with information she had seen on television about a newer drug that could be added to the two she was already taking. She accepted the idea that she was depressed and it seemed reasonable that a newer, better medicine would help.

Dr. Wilson, however, was uncomfortable prescribing the new medicine. If Susan wanted to take the new drug, she would need to see a specialist. Again, Susan hesitated for just a moment. This was more than she had bargained for, but she feared quitting after investing so much time and money. She reluctantly agreed and Dr. Wilson referred her to a psychiatrist.

By this time, Susan was convinced that she had a disease that made her hurt, which was controlled by chemicals in her brain. She believed she could be cured if she just found the right medicine. And so she found herself in the office of Dr. Martha Smith, a psychiatrist and a genuinely nice person. Dr. Smith took a great deal of time examining Dr. Wilson's records and carefully discussed Susan's history and problems with her.

What came next caught Susan off guard. Instead of agreeing with her first diagnosis and writing the new prescription, Dr. Smith told Susan that she had a problem that seemed similar to depression but was really very different. Susan had a form of bipolar disorder

(bipolar disorder II). This new diagnosis would account for her depression, irritability, restlessness, anxiety, and sleeplessness.

Dr. Smith told Susan that her parents most likely had passed this problem on to her. It was a lifelong problem that could never be cured, but could be treated with medication. Once she started the medication, she would need to take it indefinitely. If she followed the instructions, Susan could lead a relatively normal life. If she did not, she would continue to suffer.

Again, the hope of a new diagnosis and treatment was almost irresistible. It did seem a little strange to go from being a normal, healthy mother of three to being permanently sick with an inherited disease. But the doctor seemed to care a great deal about her and, as always, there were free samples to start the treatment. Once again, Susan chose to take the next step in the hope that this would be the answer.

Initially, Susan continued her original antidepressant and the new medication was added. Its potential side effects were considerable, including weight gain, diabetes, and involuntary jerking and tics. On top of that, Dr. Smith prescribed an anti-anxiety medicine to help with the side effects of the original drug. All of this should help her sleep, calm her down, and relieve her depression.

Susan was now six months into treatment, and she thought it was about time for things to get better. It would have been nice had it worked that way. Instead, Susan was back two months later to get started on a fourth drug. For the next four years, this process continued as new medicines and new combinations were tried. But life never did return to normal.

One day Susan realized that it had been five years since she began treatment and she was no better off than when she started. That day she made the most important decision of her life. Susan went back to her physician and asked her to arrange a vacation from her medicine. Susan wanted to know if the medicine actually made any difference. Her doctor reluctantly agreed and gradually weaned her off the medication.<sup>7</sup> (As a physician, I would add that

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<sup>7</sup>No readers should consider stopping or changing their medication without first consulting their physician. Susan's story is one person's experience and does not apply to all people and all medical problems.

Susan's decision to involve her doctor at this point was wise. No patient should stop taking his or her medicine or change the dose without first consulting the prescribing doctor.)

I met Susan a year later. At that time, she was continuing her vacation from medication and doing better. She still had some physical pain, but considered it less of a problem than the medicine she had been taking. She had recently moved to our area and was looking for a doctor in her neighborhood. She was emphatically not looking for new medication.

Susan's story is not uncommon. As a physician, I regularly see patients who could tell Susan's story because they are living it. They want to feel better and I want them to feel better too. They are diagnosed with bipolar disorder, depression, or anxiety. They take their medicine faithfully but continue to struggle. Their families struggle along with them as those who want to help. Everyone involved is looking for some hope that the pain and problems can be fixed.

### **Questions and Answers**

Susan and patients like her resemble the sick woman who met Jesus. They are faced with pain that affects them physically and emotionally. In their search for a cure, they often see several physicians and have multiple tests done at considerable expense. They take multiple medications that may or may not help them. And, in the end, they may not be much better and may simply get worse.

The question I see in Susan's story is this: Could Jesus help her the way he helped the sick woman who touched his garment? Is it possible for the majority of people who struggle with mood disorders like depression and bipolar disorder to find help from God? Could that help be found in the Bible, where God speaks to us?

Another patient Jesus helped may point us to the answers to these questions. He was a crippled man who had waited to be healed or helped for thirty-eight years. The apostle John was the witness to this cure.

After these things there was a feast of the Jews, and Jesus went up to Jerusalem. Now there is in Jerusalem by the sheep gate a pool, which is called in Hebrew Bethesda, having five porticoes. In these lay a multitude of those who were sick, blind, lame, and withered, [waiting for the moving of the waters; for an angel of the Lord went down at certain seasons into the pool and stirred up the water; whoever then first, after the stirring up of the water, stepped in was made well from whatever disease with which he was afflicted.] And a certain man was there, who had been thirty-eight years in his sickness. When Jesus saw him lying there, and knew that he had already been a long time in that condition, He said to him, “Do you wish to get well?” The sick man answered Him, “Sir, I have no man to put me into the pool when the water is stirred up, but while I am coming, another steps down before me.” Jesus said to him, “Arise, take up your pallet, and walk.” And immediately the man became well, and took up his pallet and began to walk. Now it was the Sabbath on that day.

—John 5:1–9

There are no doctors involved here—just a sick man who had waited at the edge of pool, hoping that his superstition would make him well. The text inside the brackets is probably a late insertion, but it most likely represents what the man and most townspeople believed. Every once in a while an angel came and stirred the waters, but since the man was crippled, he couldn’t get to the pool in time. Then one day Jesus walks by and asks if he would like to be healed. The man explains that he can’t move fast enough to get there, but Jesus tells him to get up, take his bed and walk—and he did!

There are some interesting parallels to the problems we face with mood disorders today. Just like the man at the pool, we have a strong societal norm that says that if you are depressed or anxious, it is likely due to an abnormality in your brain chemicals, which can be cured by medication. Yet current research indicates that this theory may be no more certain than the hope of being cured by the troubled waters in the pool of Bethesda.<sup>8</sup>

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<sup>8</sup>J. R. Lacasse, J. Leo (2005), “Serotonin and depression: A disconnect between the advertisements and the scientific literature,” *PLoS Medicine*, 2(12):e392, [www.plosmedicine](http://www.plosmedicine).



## Unexpected Hope

When Jesus told the crippled man to walk, it required him to give up on the idea of being cured by a treatment that had not worked. After thirty-eight years of disappointment, Jesus brought hope. The truth was that the man was never going to be healed by the conventional wisdom of his day. He was healed when he met Jesus who was and is the truth. Could the answer to mood disorders and anxiety be found in this same Jesus?

By some estimates, over 25 percent of the U. S. population will carry the label of depression, anxiety, or bipolar disorder at any given time.<sup>9</sup> Research indicates that less than a quarter of them will effectively gain a remission from depression as a result of the medication they take.<sup>10</sup> That leaves the rest, a significant majority, without a good answer for their problems and, most likely, without much hope.

That is what I have seen in the years I have practiced medicine. Some people who take the medication report that they feel better; others do not.<sup>11</sup> Questions and opportunities are raised by this. When many people do not improve, could there be a problem in the way they are being diagnosed and labeled? If that were so, it

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org (4/29/12). 1212–1213. The authors state that “contemporary neuroscience research has failed to confirm any serotonergic lesion in any mental disorder and has in fact provided significant counterevidence to the explanation of simple neurotransmitter deficiency. . . . To our knowledge, there is not a single peer-reviewed article that can be accurately cited to directly support claims of serotonin deficiency in any mental disorder.” PLoS Medicine is the online medical journal of the Public Library of Science.

<sup>9</sup>NIMH: Statistics for anxiety disorders and all mood disorders. Accessed electronically at [www.nimh.nih.gov/statistics](http://www.nimh.nih.gov/statistics). The annual prevalence of anxiety disorders is estimated by the National Institute of Mental Health to be 18.1%. The lifetime prevalence is 28.8%. Annual prevalence for depression is 9.5% and lifetime is 20.8%. (4/29/2012)

<sup>10</sup>J. Blumenthal, M. Babyak, M. Doraiswamy et al. “Exercise and Pharmacotherapy in the Treatment of Major Depressive Disorder,” *Psychosomatic Medicine*, 2007; 69 (7):587–596. This study showed that those treated with sertraline, exercise, or placebo responded to treatment with remission in 47% of the patients in the sertraline group, 41% of the exercise group, and 31% of the placebo group. In this study, when the placebo effect is subtracted from the medication group, the real effect is 17%.

<sup>11</sup>The presence of a response to a medicine does not always mean that there is disease present, nor does it mean that the medicine caused the cure. Viral colds and penicillin are a good example. A lack of a response to a medicine also does not mean that there is no disease present. Things related in time are not always related by cause.

might explain why many people do not seem to benefit from the medication. What percent of those who struggle with sorrow and a depressed mood have a medical problem? The most important question has to be: Is there anything more we can offer people to give them hope? To answer these questions and take advantage of the opportunities, three areas need to be explored.

*Defining the terms.* The first step to finding hope for people identified with bipolar disorder, depression, or anxiety is to have a clear understanding of what those terms mean. There is often a big difference between the way a patient understands bipolar disorder and the way it is described by physicians and psychologists. The same can be said for depression and anxiety. As we look for hope, we will examine the history of these diagnostic labels and what they mean today.

*Understanding the diagnostic process.* The second step will be to examine how a diagnosis of depression or bipolar disorder is made and the label assigned. Many things influence this process. It is important to understand how a physician or psychologist decides that someone has this (or any) disease.

*The biblical alternative.* Over the last twenty years, there has been a major effort to educate people about depression. The main tenet of that education is that depression and mood disorders are medical problems that require medical treatment. When most people feel depressed today, they go to the doctor in search of a medical answer. Today very few would go to their pastor first and few caregivers would view the Bible as relevant to the problem.

In the third step, we will look at the ways the Scriptures offer help and hope to people who carry these labels. They have most likely already been to the doctor and gotten the same result Susan did. I believe there is comfort and direction available for anyone who has been labeled bipolar, depressed, or anxious like Susan. This applies to those who take medication and those who do not.

One of our current societal norms for mood disorders and depression is to either relate it or equate it to pain. As a current television advertisement for a popular antidepressant says, "Depression

hurts.”<sup>12</sup> The commercial makes a strong visual argument that when we hurt physically and there is no clear cause, it may be depression.

Ed Welch reflects the idea that depression hurts in his book, *Depression: A Stubborn Darkness*, when he says, “Depression is painful.”<sup>13</sup> That is how we see depression inside and outside the church. When people struggle with a depressed mood, they do hurt emotionally, and the pain they feel spreads to every corner of their lives, touching all who know and love them. Things today are much the same as when Jesus was touched by the suffering woman and when he told the crippled man to walk. Then and today, the pain and suffering are real and people want help.

While almost no one I know makes it his goal in life to be depressed, bipolar, or anxious, thousands of people carry those labels with them every day. They struggle with the burden of the label and the pain of their problems. This book aims to help them find the kind of help that Jesus wants to give to those who see him as their last and only hope.

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<sup>12</sup>Eli Lilly television advertisement for Cymbalta. This advertisement can be seen on youtube at <http://www.youtube.com/watch?v=OTZvnAF7UsA>. It was copyrighted 7/02/2009. (5/03/2012) The theme of the advertisement is that depression hurts and that the hurt is depressed mood, lack of energy, lack of interest, anxiety and other symptoms common to depression.

<sup>13</sup>Edward T. Welch, *Depression: A Stubborn Darkness* (Winston-Salem, N. C.: Punch Press, 2004), 37.

## 2

### Where Did Susan's Diagnosis Come From?

**W**hen I think about Susan and her experience with the health care system, one thing that sticks in my mind is the confusion about what disease she had. There was Susan, struggling to feel better and to know what her problem really was, and the best my profession could do left her confused and suffering. How could there be so much confusion and difference of opinion about the diagnosis of a disease?

It's easy to understand why physicians failed to make a good diagnosis for the suffering woman Luke described. Physicians of that day had little or no understanding of human anatomy. The role of bacterial infection in disease was not understood. The importance and purpose of blood was unknown. In our day MRIs, CT scans and ultrasounds give us pictures we could only imagine thirty years ago and none of it existed in the first century. The woman Luke described—and those who tried to help her—were hindered by a lack of objective scientific information to make a diagnosis and provide treatment.

It is hard to believe that the same thing could be true today for people diagnosed with depression, bipolar disorder, or anxiety. But, in light of Susan's long, unsuccessful quest for medical help, isn't it possible that doctors and patients like Susan lack the kind of information about pain, worry, and depressed moods that is needed to help them? Unfortunately, people who suffer with depression, wild mood swings, and worry *do* face the same problem. The diagnosis of these emotional disorders is much more difficult and far less certain than something like diabetes or a strep throat.

When a patient comes to my office complaining of a sore throat, fever, and a headache, the odds are that my nurse will have made the diagnosis before I enter the exam room. She will do a rapid strep screen from a swab of the throat. A positive test means that the patient will be taking penicillin for about ten days. A negative test means that the patient probably has a virus and does not need an antibiotic. All of that can be determined with one test in about eight minutes.

Even more complicated medical problems can be diagnosed in a matter of hours instead of days. A patient who presents with a headache and new visual changes may have a migraine headache. He could also have a brain tumor. Today, in a couple of hours, I can have the patient in a CT-scanner to determine with absolute certainty whether he has a tumor or not.

## **Diagnosing Depression**

I wish I could say that medicine can make a diagnosis that easily for people suffering emotional distress. It would be so helpful to be able to do a test that would help us relieve their burdens. But the test does not exist. In fact, there are no laboratory tests or x-rays that can make the diagnosis of depression.<sup>1</sup>

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<sup>1</sup>*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (Arlington, Va: American Psychiatric Publishing, 2000) 352. This manual is currently being revised a fifth time. "No laboratory findings that are diagnostic of a Major Depressive Episode have been identified." The key to the quote is the word "diagnostic." There are tests that could be said to be suggestive but to this day there are none that have been validated as diagnostic.

What we do have are criteria that must be met—a list of symptoms that must be present—in order to make a diagnosis of depression. Those criteria are found in the *Diagnostic and Statistical Manual of Mental Disorders*. For someone to be given the diagnosis of depression, five or more of the criteria must be present for two weeks and must represent a difference in the person's behavior.<sup>2</sup>

From the list of nine criteria, either a depressed mood or a loss of interest in pleasurable pursuits must be present. The symptoms cannot include any that are caused by a medical condition, delusions or hallucinations.

The list includes:

1. A depressed mood daily for most of the day, nearly every day, as indicated by subjective report or the observation of others.
2. A loss of interest or pleasure in all activities for most of the day, nearly every day.
3. Weight loss or gain of more than 5 percent of body weight due to an increase or decrease in appetite.
4. Inability to sleep normally or excessive time spent sleeping daily.
5. Visible restlessness and agitation or sluggishness and slowing down as seen by others.
6. Fatigue or loss of energy daily.
7. Feelings of worthlessness or guilt without a reason.
8. Decreased ability to think, concentrate, and make decisions.
9. Recurring thoughts of death, or suicide without a plan. Suicide attempts or plans for suicide.

For someone to be diagnosed with depression, these symptoms must cause real distress, problems with family and friends, and

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<sup>2</sup>Ibid., 356.

**DSM IV**  
**Major Depressive Episode**

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions<sup>1</sup> or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
  - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
  - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
  - (4) insomnia or hypersomnia nearly every day
  - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - (6) fatigue or loss of energy nearly every day
  - (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

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<sup>1</sup>A mood congruent delusion exists when a depressed person believes a false idea that fits with his mood. He is depressed and he believes the world is ending. A mood incongruent delusion is seen when a depressed person believes a false idea that does not fit his mood.

trouble at work. The symptoms cannot be the result of substance abuse or any medical condition. They should not be the result of grieving over the loss of a loved one. If they are, the problems must last longer than two months.

### **The Problem of Over-Diagnosis**

Most people would agree that people who report the symptoms listed certainly sound like they have a depressed mood. It seems straightforward enough in theory. The physician, mental health professional, or counselor asks the patient if she has these problems and to what degree. The problem is that, in practice, this diagnostic approach is not nearly as accurate as a blood glucose test or a rapid strep screen. There are subjective assessments being made by both the patient and the health care provider.

In fact, the current method of diagnosing people with depression is known to label more people with major depressive disorder than actually have it. In the words of Gordon Parker in the *British Medical Journal*, "Reasons for the over-diagnosis of depression include lack of a reliable and valid diagnostic model . . ." Simply put, the criteria we use simply do not work well.<sup>3</sup> The problem is that "DSM-III's operational criteria were set at the lowest order of inference." This means that the bar to justify a diagnosis of depression was set so low that almost anyone could meet it at some time in life.

In order to qualify, you only have to report that for two weeks you have been sad, blue, or down in the dumps. You would also need to have a change in appetite, sleep disturbance, fatigue and a drop in libido.<sup>4</sup> In a study conducted by Parker starting in 1978 with 242 teachers, 95 percent reported emotions consistent with a depressed mood around six times a year. When the same group was revisited in 1993, 79 percent of the group had "met the criteria for major, minor, or subsyndromal depression" as defined in the DSM. This is a very high percentage of people to qualify for the diagnosis of depression.

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<sup>3</sup>Gordon Parker, "Is Depression Over-Diagnosed? Yes," *British Medical Journal*, 335 (August 18, 2007) 328.

<sup>4</sup>Ibid., 328.



The problem with these criteria as a diagnostic tool is that they include feelings and experiences that almost everyone has in the course of normal life. Far too many normal things are said to be indicators of a disease according to these criteria. The National Institute of Mental Health currently estimates that during our lifetimes 20.8 percent of us will be labeled as depressed.<sup>5</sup> But as we saw above, the Parker study group, using the DSM criteria to diagnose depression, reported a figure of nearly 80 percent. What would happen if the diagnostic standard for pneumonia included everyone who coughs? You would have a lot more people diagnosed with pneumonia—wrongly. If you lower the standard for diagnosis, you increase the number of people who qualify for it. The suggestion that the criteria used for depression might be inflating the numbers of people diagnosed is not new. Parker is not alone in his criticism.

Jerome Wakefield concluded in a March 2010 article in the *American Journal of Psychiatry* that a criterion added to reduce the number of false positive diagnoses did not help at all. Wakefield said that a normal person faced with serious loss may develop a depressed mood that could last longer than two weeks *without* having a disease that required treatment.<sup>6</sup> He believed that some other alteration of the criteria was needed in order to reduce “false positive diagnoses” in depression. The real problem seems to be that the “test” most commonly used to diagnose people with depression is flawed. It cannot distinguish between grief that lasts more than two weeks and a real disease because it lacks a means to validate or confirm the results.<sup>7</sup>

<sup>5</sup>NIMH Statistics: Any Mood Disorder, *National Institute of Mental Health*, [www.nimh.nih.gov/statistics](http://www.nimh.nih.gov/statistics) (4/29/2012).

<sup>6</sup>Jerome Wakefield, “Does the DSM-IV Clinical Significance Criterion for Major Depression Reduce False Positives? Evidence from the National Co-morbidity Survey Replication,” *American Journal of Psychiatry* (2010) 167:298–304. [www.ajp.psychiatryonline.org](http://www.ajp.psychiatryonline.org) (5/9/2012). The problem was that “. . . diagnosis and the need for treatment are not the same. Intense normal reactions to loss and stress can include distress [and] role impairment . . . that can transiently resemble disorder.” The criterion was the requirement that symptoms cause significant distress and impairment. A second qualifier exists for bereavement, which extends the period that a person can be emotionally distressed after the loss of a loved one from two weeks to two months.

<sup>7</sup>T. Richard Manne, “Too Many People Misdiagnosed with Depression: Blame the Criteria or the Doctors?” *Science 2.0* (March 10, 2010) [www.science20.com](http://www.science20.com) (5/9/2012). We will deal with the issue of validity in chapter 5.

As a physician, I wish I could say that the problem is only with the test. The truth is, not only are the criteria flawed but most of the time physicians simply don't use them when they diagnose depression. This is the psychiatric equivalent of omitting the rapid strep screen on a sore throat. A full quarter of psychiatrists admit that, more than half the time, they do not use the DSM-IV criteria when they make a diagnosis of depression.<sup>8</sup>

It is even worse among primary care physicians, my part of the profession. Among primary care doctors, two-thirds admit that they don't use the criteria half the time.<sup>9</sup> To complicate matters further, primary care physicians think they are better at diagnosing depression than they really are. One study asked physicians how they rated their ability to gauge the severity of a patient's depression. This is very important, since the severity often dictates the treatment. In the study, 55 percent of the physicians thought they were good at rating the severity of depression. In reality they were right around 60 percent of the time, which made them only slightly better than a coin flip.<sup>10</sup>

So when it comes to depression, the queen of mood disorders, confusion reigns. The medical profession may have good intentions, but when Susan and many like her go looking for relief, they are in much the same fix as the woman in the Gospels. Without a way to make a reliable diagnosis, physicians do not know exactly what they are treating.

That leads to the experience Susan had. When her originally diagnosed mood disorder did not respond to the care she was given, Susan was diagnosed with another mood disorder, using another set of criteria. Unfortunately for her and her physicians, there was and is no objective test that can make a diagnosis of bipolar disorder

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<sup>8</sup>Mark Zimmerman, "Psychiatrists' and Non-psychiatrist Physicians' Reported Use of the DSM-IV Criteria for Major Depressive Disorder," *Journal of Clinical Psychiatry* 2010; 71(3):235–238.

<sup>9</sup>*Ibid.*, 235.

<sup>10</sup>Ingrid Olsson, Arnstein Mykletun, Alv A. Dahl, "General practitioners' self-perceived ability to recognize severity of common mental disorders: An underestimated factor in case identification?" *Clinical Practice & Epidemiology in Mental Health*. 2:21 (2006) *PubMed Central*, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1560123/> (5/10/2012).

It easy or certain. Again Susan found herself answering a list of questions about her behavior.

### **Elusive Criteria**

The criteria for the kind of bipolar disorder Susan was supposed to have are as follows:<sup>11</sup>

1. One major depressive episode is required.
2. One period of hypomania is required. This is defined as an elevated mood in which she had more energy, was disorganized, had racing thoughts, irritability, anxiety, insomnia, and agitation. To make things even more uncertain, the mood could be negative *or* positive. During hypomanic episodes, patients may complete more work than usual. Hypomania should not be confused with euthymia, a short period when the depression lifts and the individual feels emotionally normal.
3. The individual has never had mania or been diagnosed with bipolar disorder I.
4. The episodes cannot be better explained by a general medical illness, adverse reaction to medicine, substance abuse or another psychiatric disorder such as schizophrenia.

One would hope that the diagnosis of BPD could be made more easily and accurately than that of depression, but that is not the case. There are two reasons for this that are similar to the problems involved in diagnosing depression. First, in order to receive a diagnosis of bipolar disorder, an individual must have an episode of major depression, and we have seen how that diagnostic process is fundamentally flawed. Then, the same subjective approach is used to diagnose the required episode of hypomania.

As with depression, there are no laboratory, x-ray or physical findings that help physicians to make this diagnosis. We simply

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<sup>11</sup>*Diagnostic and Statistical Manual of Mental Disorders*, 392.

have a list of behaviors that are supposed to be observed. We ask patients about these behaviors using a questionnaire or by taking their medical history. As Susan found out, the likelihood that a patient will be given a label that does not help him is great. Physicians who really want to help lack an accurate and reliable tool to use. Patients risk receiving a diagnosis that may be inaccurate, leading to treatment that does not help.

There can be no doubt that most physicians enter medicine because they want to help people. None of us like to read about patients who have the wrong knee replaced or who suffer ill effects because the wrong medicine is given. I frequently remind my students that doctors do not get up in the morning thinking of ways to hurt people! No, they dedicate a significant portion of their lives to study, hard work, and sleepless nights to learn a profession that allows them to help.

That being so, why does it seem that we are trapped with a diagnostic process that labels so many without helping them? Physicians seem to be hampered by the way they decide if someone is depressed or has bipolar disorder. How did we get into this fix? Understanding how we got here is the first step for getting out of the label trap.

I have practiced medicine for thirty-seven years. I am old enough to say with conviction that we have not always diagnosed most diseases the way we do today. In most cases this represents progress, in that tests are quicker and more accurate now. The way we diagnose mood disorders has also changed, but it remains a difficult thing. A short look at the history of how we make that diagnosis might help us understand the problems we face today.

## **The Changing Description of Mood Disorders**

The history of depression and bipolar disorder is a complicated one because for the last 200 years, the diagnosis of mental disorders has largely been a matter of “expert” opinion. And there were lots of opinions that gave us labels like circular insanity, cycloid psychosis,

and folie circulaire.<sup>12</sup> Without objective evidence such as laboratory, x-ray, or even physical exam findings, the diagnosis of mood disorders was made using a history of the patient's behavior and his family history. This is still true for most mental disorders, except for those connected to medical diseases that can be detected through objective tests, such as hyperthyroidism and Cushing's disease.<sup>13</sup>

After 1900, the "art and science" of medicine took a hard turn towards science. Discoveries in scientific areas such as chemistry were finding their way into the practice of medicine. As a result, the medical profession became more objective. With William Perkin's discovery of dyes that could stain cells and Paul Ehrlich's use of those dyes, medicine was on its way to becoming a profession based on facts.<sup>14</sup>

Ehrlich gave medicine and psychiatry an amazing gift when he took the purple dye Perkin developed and used it to stain tissue samples from patients with various kinds of diseases. His colleagues did the same in the Charite mental hospital in Berlin. Ehrlich and his colleagues examined the stained tissue under the microscope. They discovered that half the residents who had been judged as "simply" insane actually were suffering from infectious diseases that had damaged the brain.<sup>15</sup> One simple, objective test provided a factual result that changed the course of medical history. Medicine was beginning the march toward verifiable, repeatable, factual evidence as the basis for the diagnosis and treatment of disease.

While medicine in general was busy defining disease in as factual a way as possible, psychiatry at the time had only the personal observations of practitioners and the theories that grew from their observations. By 1950, psychiatry was seeking a vocabulary that would enable it to be more scientific as well. The new terminology first appeared in a classification of disease written by Emil Kraepelin

<sup>12</sup>For a very good history of the diagnosis of mania, see *Mania: A Short History of Bipolar Disorder* by David Healy (Baltimore: Johns Hopkins Press, 2008).

<sup>13</sup>Appendix B discusses medical diseases that affect mood and behavior.

<sup>14</sup>Gary Greenburg, *Manufacturing Depression* (New York: Simon and Schuster, 2010), 44–49. This is an excellent history of the birth of modern medicine.

<sup>15</sup>Greenburg, *Manufacturing Depression*, 48–58.

in 1893.<sup>16</sup> This book suggested no treatments because Kraepelin did not believe that the diseases he described could be treated. But Kraepelin's book gave physicians caring for mental patients a common language to use in identifying the behavior they were seeing.

In 1952, the psychiatric world witnessed the publication of the first Diagnostic and Statistical Manual of Mental Disorders. This reference work was not intended to be a re-creation of the Kraepelin text, but in some ways it was just that. The DSM did not dictate the best way to treat or even diagnose all the disorders listed in its pages. However, it did offer an agreed-upon description of each "disease" and the criteria that had to be met for someone to qualify for the diagnosis. (It also provided a code that was required for the psychiatrist or other provider to bill for services.)

In 1980, the term bipolar disorder appeared in the DSM 3rd revision in place of manic depression.<sup>17</sup> The purpose was to clarify the difference between manic depression and schizophrenia. But there was more to it than that. At the same time, the committee added the categories of bipolar disorder II, cyclothymia, and bipolar disorder NOS (not otherwise specified). The NOS category allowed psychiatrists some "wobble room" to diagnose patients with bipolar disorder who might not meet the whole standard. This made it easier to label a patient as bipolar.

Before this change was made, a patient had to be hospitalized with a life-disrupting episode of mania to be given a diagnosis of manic depression or bipolar disorder I. This made the diagnosis of manic depression much simpler—and much less frequent. But now physicians and psychologists were given less specific criteria and several more options to consider in making the diagnosis.

The end result is that people with very dissimilar problems wind up with the same labels: depression and bipolar disorder. And a lot more people are assigned those labels. Susan was one of millions in our country to be diagnosed with depression or bipolar disorder and then treated medically.

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<sup>16</sup>Greenburg, 71–74.

<sup>17</sup>David Healy, "The Latest Mania: Selling Bipolar Disorder." *PLoS Medicine* 3:4 (2006) 3 [www.plosmedicine.org](http://www.plosmedicine.org) (3/28/2012).

Many of these individuals have one more thing in common with Susan: they receive little benefit from their diagnosis or their treatment. In the January 2010 issue of the *Journal of the American Medical Association*, a large study found that in patients with mild, moderate, and even severe depression, a placebo had the same therapeutic benefit as an active antidepressant medication.<sup>18</sup> Depending on the study, patients in these three categories make up 70 percent to 87 percent of all patients who present with depression.<sup>19 20</sup> The study concluded that unless a person had very severe depression, a placebo pill was as effective as antidepressant medication.<sup>21</sup> Even when treating very severe depression, the placebo effect could account for up to 80 percent of the effect of the antidepressant medication.<sup>22</sup>

There are many ways to interpret this information. Perhaps the first point is that this does not mean that no one is helped by the medicine available to treat depression today. Even if less than 10 percent of those who take the medicine are helped, we should be glad for them. The second point would be that no one should stop taking or adjust their medication without first consulting their physician. But the third and (I would argue) most significant point is that the current approach to the diagnosis and treatment of depression fails to help a large portion of those who need it.

Medical researchers continue to look for a way to identify a physiological cause for depression and we should be glad they are. When

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<sup>18</sup>Jay Fournier, Robert DeRubeis, Steven Hollon et al. "Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis," *Journal of the American Medical Association*, 303:1 (January 6, 2010) 51. "True drug effects (an advantage of antidepressant medication over placebo) were non-existent to negligible among depressed patients with mild, moderate, and even severe baseline symptoms. . . ."

<sup>19</sup>Mark Zimmerman, Michael Posternak, Iwona Chelminski, "Symptom Severity and Exclusion from Antidepressant Efficacy Trials," *Journal of Clinical Psychopharmacology*, 22:6 (December 2002) 610–614. In this study 70 percent of those presenting with depression were considered mild, moderate, or severely depressed.

<sup>20</sup>Sharon Begley, "Anti-Depressants Don't Work, Do Work: The Debate Over the Nation's Most Popular Pills," *Newsweek* (February 8, 2010) 39.

<sup>21</sup>Fournier, "Antidepressant Drug Effects," 51.

<sup>22</sup>Irving Kirsch, Brett Deacon, Tania Huedo-Medina et al. "Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration," *PLoS Medicine*, 5:2 (February 2008) 266. [www.plosmedicine.org](http://www.plosmedicine.org) (5/13/2012).

Paul Ehrlich and his colleagues were busy staining cells, the result was that the number of people diagnosed with “insanity” dropped by half.<sup>23</sup> Truth is never an enemy in the pursuit of understanding and curing disease. A real understanding of the cause at a cell level for depression would allow an accurate, repeatable test. It would greatly reduce inaccurate over-diagnosis.

Ehrlich put it best when he said, “It should be possible to find artificial substances which are really and specifically curative for certain diseases, not merely palliatives acting favorably on one or another symptom . . . .”<sup>24</sup> As things stand today, we have not reached that goal for the diagnosis and treatment of depression. We certainly lack the tests, and the medicines are far less effective than had been hoped.

For Susan and those like her within the 87 percent who do not seem to benefit much from current treatment, it means that they may still suffer the same fate as the woman with the hemorrhage in Jesus' day. The labels they receive and the prescriptions they are given might only result in more labels and prescriptions without a cure and at some expense. This opens a door of opportunity for us to look at depression from a different angle.

Even in a nation with the best health care on earth and the best doctors in history, the labels may be wrong and the treatments may not work well. It has been that way for as long as physicians have tried to diagnose and treat disease. At times we are wrong, and changing those wrong ideas has proved to be hard. But it is time for us to do just that. We can assume that a small portion of those who fit the current criteria may have a medical disease whose cause is yet to be discovered. But while we wait for that discovery and better treatment, we could be doing something for the 87 percent who don't seem to benefit from current diagnosis and treatment.

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<sup>23</sup>Greenberg, *Manufacturing Depression*, 57. “By one count, nearly half of the patients in Europe's mental hospitals were suffering from tertiary syphilis.” The symptoms of untreated late syphilis were interpreted as insanity at the time.

<sup>24</sup>Ibid., 53. After identifying spirochetes as the cause of syphilis, Ehrlich set out to find a chemical compound to kill them and cure patients of syphilis. On his 606<sup>th</sup> attempt, salvarsan, an arsenic compound, was found to kill the organisms and cure the disease, and the course of medicine changed forever.



Instead of assuming that everyone with a depressed mood has a disease that requires medical treatment, it could be that we are looking at people who are simply sad for a variety of identifiable reasons. If we are going to help those who struggle with mood disorders, we need to have a better understanding of what is or is not a disease. In the next chapter, we will examine a few ideas that should help us distinguish sadness from disease.