body, mind & soul

Lee Iacocca
Businessman

In times of great stress or adversity, it's always best to keep busy, to plow your anger and your energy into something positive.

Is sadness a disease?

The blurring of lines between natural sadness and depressive disorders has proved very lucrative for psychotherapists and drug firms. But we might be better off if depression is redefined to take into account the context in which it occurs, argue Allan V Horwitz and Jerome C Wakefield

Sadness is one of the few human emotions that have been recognised in all societies and in all time periods. Some of the earliest-known epics, such as *The Iliad* and *Gilgamesh*, feature protagonists' intense sadness after the loss of close comrades. Likewise, anthropological work across a great range of societies clearly describes emotions of sadness that develop in response to frustration in love, humiliation by rivals, or the inability to achieve valued cultural goals.

Even primates display physiological and behavioural signs after losses that are unmistakably similar to sadness among humans. There is little doubt that evolution designed people to have a propensity to become sad after such situations.

Depressive mental disorders also have been known for as long as written records have been kept. Writing in the fifth century BC, Hippocrates provided the first known definition of melancholia (what we now call "depression") as a distinct disorder: "If fear or sadness last for a long time it is melancholia." The symptoms that Hippocrates associated with melancholic disorder — "aversion to food, despondency, sleeplessness, irritability, restlessness" — are remarkably similar to those contained in modern definitions of depressive disorder.

Like Hippocrates, physicians throughout history have recognised that the symptoms of normal sadness and depressive disorder were similar. Depressive disorders differed from normal reactions because they either arose in the absence of situations that would normally produce sadness or were of disproportionate magnitude or duration relative to whatever cause provoked them.

Such conditions indicated that something was wrong with the individual, not with his environment. Traditional psychiatry thus adopted a contextual approach to diagnosing a depressive disorder. Whether a condition was diagnosed as disordered depended not just on the symptoms, which might be similar in normal sadness, and not just on the condition's severity, for normal sadness can be severe and disordered sadness moderate, but on the degree to which the symptoms were an understandable response to circumstances.

The distinction between contextually appropriate sadness and depressive disorders remained largely unchanged for two and a half millennia. But the psychiatric profession abandoned this distinction in 1980, when it published the third edition of its official diagnostic manual, the DSM-III.

The definition of Major Depressive Disorder (MDD) became purely symptom-based. All conditions that display five or more of nine symptoms — including low mood, lack of pleasure, sleep and appetite difficulties, inability to concentrate, and fatigue — over a two-week period are now considered depressive disorders.

The sole exception is "uncomplicated" grief-related depression. Symptoms otherwise meeting the DSM criteria are not considered disorders if they arise after the death of an intimate, do not last more than two months, and do not include certain particularly severe symptoms. Yet, comparable symptoms that arise after, say, dissolution of a romantic relationship, loss of a job, or diagnosis of a life-threatening illness are not excluded from the diagnosis of disorders.

The DSM-III's confusion of normal intense sadness and depressive mental disorder emerged inadvertently from psychiatry's response to challenges to the profession during the 1970s. A powerful group of psychiatrists was dissatisfied with the definitions of depression in the psychoanalytically-influenced manuals.

These earlier definitions separated feelings of sadness proportionate to contextual loss from those excessive to their contexts, and defined only the latter as disordered. But they also assumed that unconscious, unresolved psychological conflicts caused depression. In order to abolish this unwarranted psychoanalytic assumption, the researchers abandoned the attempt to distinguish natural from disordered conditions by context and assumed that all conditions that met the symptom-based criteria were disordered.

> **Earlier definitions of depression did not include sadness arising from, say, the loss of a job**

The new definition of depression has resulted in extensive medicalisation of sadness. Parents whose child is ill, spouses who discover their partners' extramarital affairs, or workers unexpectedly fired from valued jobs are defined as suffering mental disorders if they develop enough symptoms to meet the DSM criteria. This is so even if the symptoms disappear as soon as the child recovers, the spouses reconcile, or a new job is found.

The medicalisation of sadness has proven to be of tremendous benefit to the mental health profession. Millions of people seek help for conditions that fall under the overly inclusive definition of depression. Indeed, depression is now the most commonly diagnosed condition in outpatient psychiatric treatment.

The medicalisation of depression has proven to be even more profitable for pharmaceutical companies, whose sales of anti-depressant medications have soared. While it is impossible to know what proportion of these people are experiencing normal sadness that would go away with the passage of time or a change in social context, it is almost certainly very high.

It would not be hard for psychiatry to develop a more adequate definition of depressive disorder that de-medicalises natural emotions of sadness. The diagnostic criteria could simply extend the current bereavement exclusion to cover conditions that develop after other losses and that are not especially severe or enduring.

Such a change would acknowledge what humans have always recognised: intense sadness after loss is a painful and perhaps inevitable aspect of the human condition, but it is not necessarily a mental disorder.

— Allan V Horwitz is Professor of Sociology at Rutgers University. Jerome C Wakefield is Professor of Psychiatry at NYU School of Medicine. *Copyright: Project Syndicate,2009*

thinksunday@gmail.com

ART OF GIVING

Helping them to find their own feet

Malini Nair looks at an example of philanthropy that does not create dependents

VK Sharma, an HR advisor with JK Tyres, belongs to a new breed of philanthropist who worries about the long-term impact of his giving. He used to donate generously to a slew of NGOs till a thought struck him: was he just supporting a culture of dependence among his beneficiaries? Should he not be doing more to help them find their own feet in some manner?

This is when he came across Sampradaan and the off-beat work it is doing. In these days of online giving and NGOs that function like MNCs, Sampradaan's philosophy would seem almost naively idealistic. It believes that the community that needs philanthropy should raise its own resources. It could be Rs2 or an hour of *shramdaan*, but the needy should donate to themselves. It believes that no human being is totally selfish.

"Most NGOs do not take into consideration the aspirations of the beneficiaries. They raise funds and then use them in the manner they think is right. But it is important that the beneficiaries have a role in decision-making. This can only happen when they themselves contribute towards their own cause," says Pradeepta Kumar Nayak of Sampradaan.

Currently, Sampradaan has community foundations in Haryana, Uttaranchal, Coorg, and Orissa. In the north, issues relate to education, employment, health and natural resources. The Coorg foundation, which is relatively better off, is working on the conflict between man and animal in its forested regions. It has managed to raise funds to set up its own solar fences that clearly demarcate the forests from the inhabited lands.

Major General (Retd) APS Chauhan volunteers his time heading the Sainik Foundation in Uttaranchal's villages. These villages have a large number of retired soldiers who, along with the farmers, make for a great pool of volunteers. The foundation exhorts villagers to contribute to their own fund and then matches it with a donation. "Our villages no longer have the sense of community they once did because the panchayats have become politicised," says Maj Gen Chauhan.

In Dhamand village, the Mahila Mangal Mandal has managed to raise Rs10,000 which burgeoned to Rs24,000 with the foundation's help. This money will go into setting up sewing classes and other facilities for the women of the village. The foundation has set up 10 such *gram kosh* (funds).

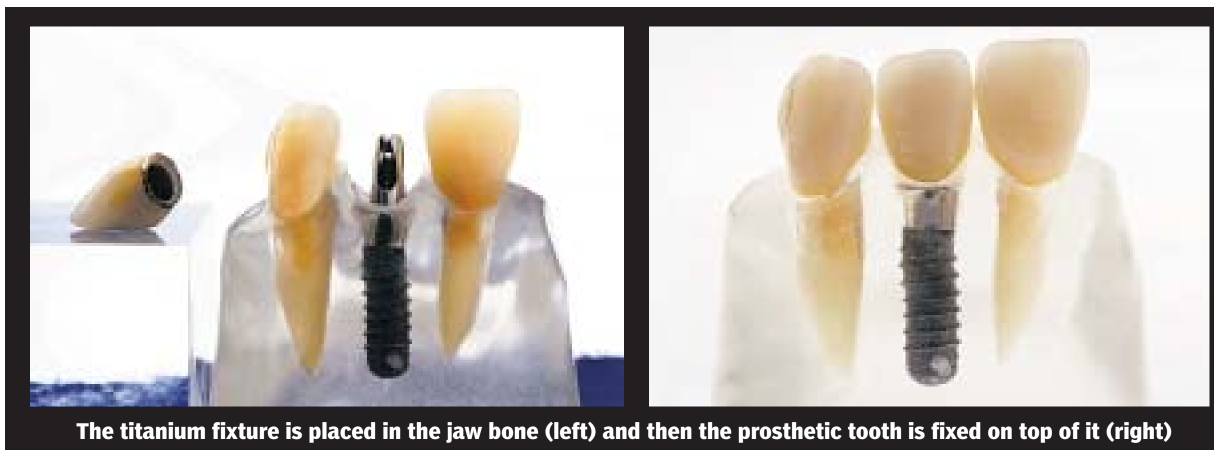
Sampradaan does get corporate and individual donors but the push is to get the communities to generate the funds they need for welfare schemes. Fund-raising from very rich sources, it finds, is a problem because such donors look for big and established NGOs to pour money into.

But the approach of donors like VK Sharma has its strengths. "I like the idea that a contribution I make can get a needy person to stand on his own feet and work towards a better future and not get more dependent on me," says Sharma.

n_malini@dnaindia.net

An implant may be better than a bridge over troubled teeth

It's a permanent solution and also makes it easier to keep the remaining teeth and gums healthy, dentists tell Sanghamitra Bhowmik



The titanium fixture is placed in the jaw bone (left) and then the prosthetic tooth is fixed on top of it (right)

If you're young and healthy, but have a rotten or broken tooth that needs to be extracted, you might be better off today going for a dental implant instead of the bridge that used to be standard procedure. The main reason is that it is a more permanent solution, and greatly reduces the chances of having to go back under the dentist's drill every few years.

"The success rate of an implant these days is 96 per cent over a period of 10 years, which means the chances of failure are almost negligible, whereas one out of three bridges will go bad in five years," points out Santa Cruz based dentist Rajneesh Sethi. This also means implants may be cheaper in the long run, even though their initial cost usually works out two to three times that of bridges.

The success of implants has come from dramatic improvements in materials, techniques and facilities. "No other branch of dentistry has advanced as much as implants over the past decade," says Dr Sethi.

NATURAL FEEL

An implant consists of a titanium screw that goes into the jaw bone. Capped with a false tooth and crown, it not only looks like a real tooth but also feels like one because pressure on the implant stimulates the underlying bone. The quality of the material used for the screw has improved along with the 3D imaging and machines available to fix it into the bone.

These developments, along with the growing band of people who can afford it in metros like Mumbai, are making implants the preferred option for those who need to replace missing teeth. "I do an average of 10-12 dental implants every month, which is significantly higher than what I used to do a year or two earlier. The main reason is that in the dental implant procedure, the adjacent teeth remain unaffected," says Kandivili-based dentist Amit Gupta.

That's a compelling reason if you understand the composition and structure of teeth. When a bridge is used in place of a missing tooth, the adjacent teeth are also filed and crowned. "It means we use two teeth to support one false tooth, whereby putting pressure on the teeth structure," explains Dr Sethi. "This is eliminated in a dental implant procedure where the false tooth is held in place by its titanium screw fixed to the underlying bone."

"Dental implants have several advantages," adds Dr Gupta. "Besides saving the adjacent teeth, the titanium fixtures used in dental implants give a more 'natural' feel to teeth and don't give rise to any noticeable speech problems."

ORAL HYGIENE

Most important of all, implants can be brushed and flossed just like natural teeth, unlike bridges where the crowns on the adjacent teeth prevent proper cleaning of the gums and space between the teeth. This is why a number of bridges end up with infections, and have to be replaced.

Despite the advantages, however, dental implants are not for everyone. Since the titanium fixtures are implanted into the bone, elderly people with a weak bone structure may not be able to withstand them. "In extreme cases, the jaw can crack under the impact of drilling in the titanium screw. So care must be taken in deciding if a patient is suitable for a dental implant," cautions Dr Sethi.

Diabetics too are usually discouraged because blood sugar can affect the integration of the implant with the bone. Poor oral hygiene is another contra-indication because of the likelihood of an infection developing in the implant.

For all these reasons, an implant is usually preceded by a battery of tests. "A bone volume analysis, CT scan and analysis of the nerve endings and those of the adjacent teeth are necessary, since inserting a dental implant requires precision," says Dr Durgesh Aroor.

So, although any dentist can legitimately perform the procedure, it would be prudent to go to one who has built up a good reputation in implants.

b_sanghamitra@dnaindia.net

BUT IT'S NOT FOR...

- Smokers whose poor oral hygiene can react with fixtures
- Those who chew tobacco as it puts pressure on teeth
- Diabetics, as blood sugar can affect the binding of fixtures
- Those with a weak bone structure that cannot take the fixtures