



LIVING WITH CHRONIC DEPRESSION

A REHABILITATION APPROACH

Jerome Levin Ph.D.

Living With Chronic Depression: A Rehabilitation Approach

by Jerome D. Levin, Ph.D.

There is a crack, a crack in everything.

That's how the light gets in.

—Leonard Cohen

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Preface

This is a book addressed to those who suffer from chronic depression, those who love them, and those who treat them. Chronic, unremitting, and endlessly recurring depression are killers. So is the acute, severe depression that often punctuates continuing, underlying, less severe depression. They literally shorten many lives and impoverish even more. Not only a murderer, depression is a thief; it steals the joy of life. As it weighs down with implacable heaviness, it even obviates Leonard Cohen's "crack that lets the light get in." Echoing William Styron's title of his encounter with depression, it is "darkness visible" as it smothers the light. Heavy, stark, and implacable, it feels unbearable. There's a whole library of books out there telling you to just change your attitude, wag your tail, and walk on the sunny side of the street. You should tell them and their authors to go fuck themselves.

Let me talk about those books. In one way or another they extol the power of positive thinking and in one way or another they offer a mind cure. If you'd only adjust your attitude, expectations, worldview, self-

concept, and philosophy, all will be well. Unfortunately, for a very large number of people that is simply not true. I assume that if you're reading this book you are one of them, or you are married to or a parent of one, or you are a therapist feeling like a failure who is treating one.

Evangelical hopefulness is in itself depressing, especially if you are already depressed. Let me tell you about Negative Mike. A number of years ago Negative Mike was a regular attendee at Manhattan Alcoholics Anonymous (A.A.) meetings. A.A., an organization for which I have enormous respect, can be aggressively upbeat, even Pollyannaish. As one member after another would say something to the effect of "My worst day sober is better than my best day drunk" (which is undoubtedly true) during the "sharing," Negative Mike would raise his hand, get recognized, and say, "My name is Mike and I am an alcoholic." He would then boom out, "We are all doomed!" and sit down. Negative Mike made a tremendous positive, if I may use that word, contribution to New York A.A. during that era. He articulated the unspoken, mostly unconscious, subtext of what was going on in the minds of many of the attendees of those meetings. He was able to express, however hyperbolically, the unspeakable, thereby giving others the freedom to experience their ambivalence about recovery. As my therapist readers

would say, he made manifest the unconscious negative transference. In writing this book, I propose to be the Negative Mike, or in my case, the Negative Jerry of the depression industry.

All these books are popularizations in one way or another of the basic message of cognitive therapy and I must concede they are excellent in their own way. Such “mind cures,” as they were called in the nineteenth century, have a long and honorable history, going back to the Roman Stoic philosophers. Marcus Aurelius comes to mind. When I was a graduate student in philosophy at McGill University I came down with a really miserable cold-flu syndrome. My concerned girlfriend asked me what I was doing for it, to which I replied, “I’m reading Marcus Aurelius.” I don’t remember whether or not the philosophical Roman Emperor raised my spirits, but he certainly didn’t cure my upper respiratory misery. The Stoics’ message was basically that nothing is good or bad in itself; thinking makes it so. *Ipsa facto*, change your thought pattern and whatever was depressing you will lose its power. The Stoics deduced a powerful corollary to their basic premise, namely, that nothing can hurt a good man.

Several centuries later, Boethius, writing from a prison cell, gave a Christian twist to Stoic philosophy. Concluding that *Fortuna* was a fickle

goddess, as witness his fall from power and prosperity to impoverished imprisonment, Boethius taught that we can rise above our circumstances to arrive at an inner calm and mental peace. Boethius called this the consolation of philosophy, which was his title. His philosophy was undergirded by Christian faith. Rather Buddhistically, he urged detachment from desire. The modern formulation would be to put in the effort without trying to dictate the outcome.

More than a thousand years later, the seventeenth-century Jewish-Dutch philosopher Benedict Spinoza taught that “freedom is the acceptance of necessity” and that such acquiescence in what must be liberated man (and even perhaps woman) from what he described as “human bondage.” Another pre-cognitive therapy mind cure.

In the nineteenth century, William James, who himself was a major sufferer of depression, turned the deterministic Spinoza on his head, self-analyzing his despair as a product of the prevailing scientific rejection of “free will.” He stated that the various arguments for and against the existence of free will, or of its opposite, determinism, were equally unconvincing. Accordingly, he declared that his first act of free will would be to believe that he had it and that he was a free moral agent, thereby lifting his depression, at least to the extent of allowing him to get

off his parents' couch and finish medical school. James, a fervent believer in the "mind cure," nevertheless suffered repeated recurrences of his depression.

Then there's Norman Vincent Peale and *The Power of Positive Thinking*. Nothing against Dr. Peale, but one of my more tormented-by-recurrent-depression patients is a wildly enthusiastic believer in the power of positive thinking. Perhaps, that has helped her, but it certainly has not cured her depression.

I shall have more to say about cognitive therapy in the section on treatment, but for now let me simply say that cognitive therapy helps many recover from depressive episodes and that all those self-help books offering one version or another of it can also be helpful. Nevertheless, my considerable experience is that neither is a long-term cure for the more serious forms of chronic depression.

There is also a glut of books teaching meditation, relaxation, forgiveness, and "spiritual" uplift of one sort or another. These, too, are touted as cures for depression. They, too, often help, but they do not cure. In fact, I've treated patient after patient who has told me that both the cognitively inspired and the uplift literature that they've read so avidly

wound up making them feel *worse*. Sometimes their therapists' unrealistic expectations (real or imagined) make them feel worse still. You may identify with these patients of mine.

Being unable to successfully avail yourself of any of these panaceas, you feel like a failure—not that you didn't feel that way before having something (all these books) to reinforce your feelings of failure. There must be something wrong with you—wrong in a moral sense—for you to have failed to recover as the books and perhaps a misguided therapist have told you you should. All in all, great fuel for your self-hatred furnace.

Then there are the biological treatments (of which I have more to say below), primarily antidepressant drugs. They, too, often help. There's no doubt that they have substantially improved the lives of some who suffer from depression. If you are among the many who have been strong responders to antidepressant meds, you are not reading this book. Rather, you must be one of the “treatment resistant,” a damning phrase if there ever was one. Almost nobody says in print, let alone in the media, that many people suffering depression are little aided by antidepressants, or that they often lose their efficacy over time, or that their side effects in

doses some need to get therapeutic response are so hard to live with that the sufferer joins the non-compliant.

So I will say the unsayable. The unhappy truth is that for some, in fact a large number, of those suffering from *chronic depression*, there is no cure. Rather, there are treatments, psychological and biological, that help, and they are most certainly worthy trying, however limited their effects or the duration of those effects. One of the worst things you can do is to self-label and you may have had all too much help with that label as a “treatment failure.” You need to hear the truth that depression can be a bitch and a half and that you are not responsible for that. *Chronic depression* is a *disability* and what is called for is an adjustment to this disability: learning to live with and in spite of it, learning how to get the maximum satisfaction out of life that is possible, both during interludes between depressive episodes and insofar as possible during the episodes themselves. This is the *rehabilitation approach*, one that is clearly needed; yet to the best of my knowledge, nobody has proposed it. I’m doing so, and in doing so not promising you too much while suggesting a coping strategy for what Winston Churchill, another sufferer from depression, called “black dog.”

Being depressed is depressing, and nobody says that either, however obvious it may be. Being chronically depressed is also infuriating, and what you do with that fury is fateful in determining how satisfactory a life will be possible for you. Amazingly, this, too, isn't discussed except in professional psychoanalytic literature.

Mourning is crucial to the rehabilitation approach. Mourning has a multifaceted relationship to depression. Failure to mourn often causes depression and depression itself needs to be mourned. You who suffer chronic depression need to mourn the losses that entails, the diminution of possibility, the very real pain and limitations imposed by the disease. Mourning is hard work; yet in the best of cases it comes to an end with acceptance. Facilitating that mourning *is* something therapists can do to help. So can writers, and that is something I hope to assist you in doing.

The acceptance of disability may be a Zen paradox, radically altering the existential meaning of the disability and even the disability itself, this being especially true when the disability is an emotional one. As I have said, I don't want to promise too much and make the same error the authors on depression I've criticized for being too Pollyannaish do about the curative powers of my approach. Nor do I wish to sound like someone advising the quadriplegic to "suck it up." Nevertheless, the Zen-

like paradoxical effect of mourning and accepting disability, including chronic depression, is real. Aristotle starts his treatise on ethics by stating that “Man by his nature desires to know.” I agree. Insight and knowledge help, even when they can’t cure. Accordingly, I will try to convey to you what we know or theorize about depression, its causes, and its treatment.

Chapter 1: Ron Smith's Story

What is *chronic depression*? Before trying to answer this question scientifically or theoretically, let me share an instance. Dr. Ronald Smith came to me in his early sixties, having felt hurt and misunderstood by his previous therapist. He told me the following story. Try to identify with the doctor, not in the particulars of his life, but rather in the pain of his depression.

“Dr. Levin, I’ve no idea what happened or why. I was a reasonably happy child. My parents fought a lot, one of my sisters committed suicide, and one of my brothers died of a drug overdose, so it couldn’t have been such a bed of roses. But I remember it that way. Happy. I had artistic talent and started drawing, later painting, very young. My father, in particular, was very proud. He would show my work to guests and I really got off on that until puberty when I became very shy. But there was a lot of fun. We skied and had summer trips to the mountains. I had friends. I did well in school. Nothing, I repeat nothing, forecast the misery and failure of my adult life. In high school my art teachers told me I would never be more than a gifted amateur. I don’t remember being

hurt by that. I never actually thought of a career as an artist. My parents joked that I might be a genius, knowing that wasn't true, and wanted me to have a more conventional, safer profession. My father taught biology in a junior college and had pushed me towards medicine. The only problem was I was lousy at science—well, not quite, but not very good. If I suffered disappointment about not having the stuff to be an artist, it passed. I was a reader and discovered Freud early. He intrigued me. My guidance counselor suggested clinical psychology as an alternative to medicine. I didn't even know there was such a thing. But that's what I am, a clinical psychologist. I'm embarrassed, ashamed to tell you that. For you see, I had a depressive breakdown in my late twenties and I haven't really recovered since. Better times and worse, but never really well. Me, a psychologist! So sick in the head I can't work. I haven't held a job or practiced for the past thirty years.

“I was in the army when it happened. That doesn't make sense either. I loved the army. I was an officer. I enjoyed the life; the structure and discipline appealed to me. I got to travel. Yet I wound up in a booby hatch—a military one—just like the ones I had staffed. It's appalling; it's humiliating. You'd think that after all those years it wouldn't bother me. But it does, especially knowing I was coming here and would have to tell

you. Such shame. I'm sick of shame. It's haunted me since I was thirty. And my last shrink—I've had lots of them—told me that I was one of those 'treatment-resistant' cases that don't want to get well. I got angry—something very unusual for me—and I became assertive. I have a tough time talking back to authority figures, but I told him he was a sadistic idiot and ran out of the room. That felt good, but not for long. I got scared. I realized that I couldn't be without a therapist, so I called you.

“Let me tell you more about my breakdown. No, let me tell you something about my 'pre-morbid' self and its—that is my—earlier experiences. I knew from my studies that there is often a 'red line' running way back before people get sick. I don't have one. When I was a kid and into Freud my family joked that I should be a psychiatrist. So I don't think they thought me very strange then.

“But I do remember a few traumatic—sort of cumulatively traumatic—aspects of my childhood. My mother never punished us. Instead she would say to me (I'm not sure if she said it to my sibs), 'I'm going to drop dead from you,' when I misbehaved. Not that I did much of anything. I was a very docile, obedient kid. She would say 'You're going to be the death of me' or 'I'm going to die from you' when I did things like come home from school late or punch one of my brothers. Nothing

very major. When she did drop dead, well after my breakdown, decades later, was absolutely sure that I had killed her. I was terribly depressed by then—something she hated—and I believed my depression killed her—triggered her heart attack. In my saner moments I know that isn't true. Still, when I'm real down I think of myself as a rat who killed his mother.

“Then there was sex. My parents didn't talk about it, yet I 'knew,' felt, they would be disappointed by any sexual expression by me. My father was something of a Calvinist, a tepid Congregationalist in practice, and he only had to look at me to make me feel guilty. My mother had given us enemas when we were sick—I hated them—all those cramps and ugh—yet when I felt stirrings when I was 13, I got the crazy idea of giving myself an enema. I did and I came. Speaking of ugh, even talking about it makes me sick, even now. I never did that again. I knew enough Freud to know it was a kind of incest—sex with my mother, her being the 'phallic mother' who used to be in all those papers I read in grad school. I'm blushing even now. Horrible. Killed my mother and had perverted sex with her. Again, I know that's crazy. Yet when I'm depressed I think about it—obsessively. 'You killed her, you pervert,' I used to say to myself when I was at my very worst, in my blackest depressions.

“I’m glad I told you that. Guilty secrets are tormentors. I know that, so, painful as it is, I try and talk about it. With most of my shrinks I was too afraid, too ashamed, but I told the last one and you know how that turned out.

“Unfortunately, I have a more serious guilty secret. I had sex with a patient. I was in Europe when I was in the army. Diane was in the service too. She came for anxiety and became a weekly psychotherapy patient. She was on the hysterical side and tended to exaggerate, so I’m not sure this was true. She told me that she lost her virginity to a boxer—her boxer dog, that is. Probably he humped her without penetrating, but who knows? That really turned me on—I told you I was a pervert—and when she came on to me I forgot all about interpreting the transference and asked her out. Treatment stopped and we became lovers. It wasn’t just sex; I really loved her. After a year I was transferred, and then I had my breakdown. Being separated from Diane when I was transferred was a real, deep loss for me. I still think about her and miss her. We occasionally correspond even now. Diane has grown children now and I’m sure she feels sorry for me because of the way my depression has ruined my life. I don’t think she has romantic feelings, but even if she did, I don’t think they would do me any good. My affair with Diane is the

thing I should feel most guilty about. Not about the stupid kid thing with the enema bag, but I don't. My relationship with Diane was one of the best things that ever happened to me. I don't feel guilty about it, I don't think. What I do feel is guilty about not feeling guilty. I never had another girlfriend.

“I think my mother was depressed. She used to go to her room for hours and sleep and think about God knows what. She covered it up and was cheerful around us. She had a Jewish background. I think it was her grandparents' generation that had converted. My mother had no time for religion. She said it was all balderdash. My father was active in his church and he read his Bible every day, but he didn't push it on us, at least not very hard. Still, I think he believed in Darwin more than in Christ and yet the Calvinist God of predestined damnation was vaguely present in our home. I think He played a role in my depression. I certainly feel damned. Yeah, predestined to be damned. It was never talked about but I sure as hell felt damned from the time I was thirty till now. Well, not all the time—it recurs and it recurs.

“Back to my mother. She told me, more than once, about a great aunt who had drowned falling into a river while koshering a pot in some godforsaken *shtetl* in Russia. The story seemed important to her.

Drowned koshering a pot? I doubt it. She must have been a suicide. My mother was very secretive about her past, her family, and their ancestors. My feeling—no, conviction—is that there was a lot of mental illness in her family—probably depression—and she was ashamed of it. My father would occasionally ask Mother to take us to synagogue because of her Jewish roots. She never did. It's sad, but I've gotten less comfort from religion than I've had pleasure from sex.

“My high school years were unremarkable. I did okay, had some friends, was horny, didn't do well with the few girls I approached, enjoyed sports a lot as a fan, had all the baseball stars and their stats at my fingertips, and I loved to swim. Doesn't sound depressed to me. Maybe a little. College was very much the same. The trouble started in graduate school. I was away from home for the first time and very lonely. Unlike my undergraduate psych major, I found the clinical psych program forbiddingly difficult. I worked very hard and still wound up flunking statistics and physiological psychology. I was almost thrown out, but they let me repeat those courses and two others I had barely passed. In effect, I redid the year. That was the first time I was consciously depressed. I walked around saying to myself, ‘Ron, you stupid fucking idiot.’ No great shakes in high school. Still I never flunked

anything and I did really well in college. That first year in graduate school really shook me up—washed out whatever confidence I had. And now I was overtly afraid of women. If they got to know me they'd find out I was a stupid fucking idiot. I don't think I've ever really regained my confidence. Nevertheless I plugged away, repeating the year, went on to get my doctorate, writing a pretty damn good dissertation.

“I didn't even try and get a job. I went directly into the service. That seemed like salvation. Like I told you, I came to love it. I had rank, I really enjoyed the clinical work, and I think I helped people. I was something of a patriot, so being an army officer was good for my self-esteem. Then it was the affair with Diane. When I was transferred and she didn't seem to mind, I was devastated. I had thought she loved me, while most probably to her I was, as the kids say now, a friend with benefits. And somewhere I had to feel guilty about the way that started.

“At first I broke down physically. I developed severe asthma, almost died, and was hospitalized several times. I was tested for everything: no allergies, no family history. In retrospect it was psychosomatic. There used to be a theory that asthma was triggered by separation anxiety; I think that was the case with me. I was reassigned, not to an outpatient psychotherapy unit but rather as staff in a psychiatric unit. I started

feeling utterly inadequate, got more and more anxious, and became convinced I couldn't do it. Finally, I locked myself in my apartment and just sat there eating popcorn for days. Finally my commanding officer showed up with two MPs and broke the door down. I wouldn't answer it. I must have been near catatonic. They shipped me out to a mental hospital in the States. The journey was a useless, unending humiliation. The shrink needed shrinking.

“I was an inpatient for two months, released on heavy meds, given light duty, and then allowed to resign my commission and leave the service with an honorable discharge. I went back home and got worse and worse. I would just sit for hours, full of self-hate, rage and despair. My family was at first sympathetic and supportive. They soon became furious at me. They were especially furious when I refused to look for a job. I couldn't, but they just didn't get it. They called me horrible things. One that sticks is ‘malingering parasite.’ The sister who later committed suicide was the most vicious. Finally I gave it back to her saying, ‘You insensitive bitch, I hope you die.’ And of course she did, by her own hand, and I blame myself for that, too. Guilt and I are great friends. Sort of Bobbsey twins. But that's not funny. It ruined my life.

“Those years after the service were hell. Leaden deadness, tormenting self-accusation, impotent fury at my parents and siblings, in fact at the whole world, and what felt like terminal aloneness. Nobody understood, nobody could or wanted to reach me. To try and do anything was a crippling struggle. It was like living deep underwater, desperate for air; moving was like walking in molasses. Time sometimes stopped and sometimes rushed pell-mell toward the end—toward death, which would have been welcome.

“I refused to go to therapy, which made my father ballistic. There were terrible, terrible fights. Finally, he dragged me to a shrink, the first of many. It wasn’t much help—maybe a little. And the meds—every one in the PDR [*Physicians’ Desk Reference*] at one time or another. They helped some, then stopped helping, and then I would try another. Several ‘authorities’ suggested ECT [electroconvulsive therapy]. My parents wouldn’t sign for that. The years passed. I mostly vegetated, becoming the male equivalent of Rochester’s wife in the attic. I had ‘good days’ when I went out, even went on a few job interviews but nothing came of them. My sister checked out. Then a few years later my brother OD’d. Horrible for my parents. I tried to be there for them. I just couldn’t. I was too preoccupied with trying not to drown. My father died. It didn’t

consciously affect me. I stayed with my now-alone mother for over a decade and was finally able to be helpful. The family stopped assaulting me as they came to accept my role in the family as Mom's caretaker. One of my surviving brothers would 'tease' me, calling me the 'caretaker who can't take care of himself.' I smiled and hated him.

"Over the years I got gradually better in the sense that I wasn't consciously underwater trying to breathe or pushing through molasses, but it wasn't much of a life. I tried from time to time to get back in the ballgame. I wrote some and even occasionally painted. I could never sustain it. I'd lose my drive, feel my energy draining away, and return to dormancy. I did go to major league games and there I actually enjoyed myself. There isn't much that gives me pleasure.

"Then my mother died. At least I felt good about myself—not about her dying—rather about my having taken good care of her in her last years. One of the few things I've done well in my life. It's lonely, though.

"The meds I'm on keep me stable, but the depression still threatens not so far beneath the surface. The waste of my life torments me: all that education, all the psychotherapeutic skill I had in my best years, all that stuffed libido gone to rot. It's so sad, so sad. I decided to go back into

therapy and started with your asshole predecessor. He suggested, ‘Just mourn those lost years and get on with your life.’ Mourn those lost years? I haven’t had a life, you asshole. And then he had a few choice words about my anger. ‘Isn’t it time you let go of your anger?’ Not to be angry at having been cheated of a life? ‘You’re out of your mind, you fucking asshole,’ was what I thought. I should have said it.

“I hope you’re better at your job than Dr. Foot-in-the-mouth. Are you?”

I replied, “Let’s try some therapy and we’ll both find out.” I think I’ve been helpful to Dr. Smith over what is now many years. But cure his depression? No.

Identifying with Ron Smith

Ron Smith’s lifelong depression raises many etiological, treatment, and how-to-endure issues to which I shall return. For the moment, I want to invite your identification with aspects of Ron’s experience. First, the absence of a sufficient cause, at least in his mind. Where many explanations can be given, it is likely that none will convince. This mystery about the why and how of many depressions, perhaps including yours, in spite of all the neurochemical, genetic, psychodynamic and

cognitive theories, adds to the torment. We human beings seek to understand, particularly understand pain. Yet frustratingly enough, often we don't.

Then there's the stuckness in the past, the ruminating about long past acts such as Ron's admittedly somewhat bizarre first sexual experience, which hurt nobody, or about things said or done to us, such as Ron's mother's telling the naughty child, "You're going to kill me!" Do you have such tapes running in your head that you can't erase? Then there is what I call "satanic grandiosity," the feeling, indeed conviction, that "I am the worst person in the world." Ron doesn't quite say that. Yet his readiness to say it is always there. Certainly it is one of his beliefs. You may know perfectly well at some level that it isn't true, especially since your name isn't Hitler or Stalin. Yet you can't get the thought that you're the worst person in the world out of your head. And less specifically, you may identify with Ron's self-loathing. How about being stuck in the molasses? Or the slowing down or galloping of time? You may identify with Ron's crippling feelings of shame at having the illness at all. Or with his rage at the harm it is doing to him. Or with his being depressed about being depressed. Or you may identify with Ron's guilty, shameful secrets (although yours will be different) or with his despair. Or you may

identify with the fearsome, awesome, punitive, Calvinistic God who inchoately hovers around his childhood home or with his earthly father's vocalizations of the Heavenly Father's injunctions, now becoming part of your self—an internal voice. Psychoanalysts call such internalized voices *introjects* or perhaps a better metaphor, tapes that won't erase running in your head. Such introjects powerfully contribute to depression. To make matters worse, they are often unconscious, yet no less, in fact more, tormenting.

You may identify with the family secrets and silences, especially if there is an intimation of a family curse—depression—as is true of Ron Smith's family or in your family or perhaps your strongest identification with our protagonist is with his sadness at the cost and waste inflicted by that goddam depression. If so, there's some hope here. Sadness has a complex relationship to depression. Persistent, particularly unaccounted for sadness *is* a symptom of depression. Yet to be sad is not necessarily to be depressed. *Sadness is a feeling; depression is a disease* and paradoxically, experiencing the true depth of your sadness can sometimes be an effective antidote for depression. But more of this later.

I invite, indeed urge you to identify with Ron Smith, not with the particulars of the circumstances of his life or with his individual

obsessive thoughts, but rather with his feelings and his global experience, because such identification lessens that horrible, horrible grip of isolation, uniqueness, and radical aloneness that so exacerbate the already awful stuff you endure. You don't want to lose yourself in that identification; you do want to know that you're not alone and that opens the possibility of learning something useful from your fellow sufferers. Perhaps most saliently, such identification mitigates shame and guilt, especially shame.

Defining Chronic Depression

Let us go on to review some treatment options and look at what they offer and don't offer. They can be characterized as psychopharmacological, somatic, and psychotherapeutic, respectively.

But before going there, let me say a little more about chronic depression. Its most salient feature is its persistence. The damn thing just doesn't go away. Yes, you have some pretty good interludes when it's in remission, and then there's another episode. Sort of a mental cancer. Every time you think it's gone, it's back. Maybe not quite in the same form. Ron Smith's depression sort of burned out in the sense that the radical torment of his post-service days has passed, but sadly, the gray

blackness he lives in is depressed enough. True, gray is better than black, but it's no great shakes. I once had a patient I was trying to convince to try antidepressant meds saying, "You're living in a black hole. Your life is endless blackness." Before I could press my selling point that medication might brighten his life, he interrupted, "Doctor, couldn't we say dark gray?" That feeble attempt at humor proved prognostically favorable and his depression turned out not to be chronic. Unfortunately, yours is.

Another misfortune lies in the fact that an episode of severe depression makes it more likely that you will have subsequent ones. That phenomenon is referred to as *kindling*. Staying on antidepressants—when they work—lessens the likelihood or possibly delays a new episode, so by staying on your antidepressant, you dampen the kindling, so to speak. Yet, as you know, that doesn't necessarily prevent subsequent episodes.

The American Psychiatric Association has a sort of doomsday book, *The Diagnostic and Statistical Manual of Mental Disorders (DSM)*, now in its fourth edition, revised. It is not as successful as it claims—witness that fact that illnesses come and go as new editions come out. Evidently there are political considerations in deciding what is or is not a mental illness. Depressive disorder, however, appears in all editions. Your

problem is called *Major Depression* or *Major Depressive Disorder* to distinguish it from a milder form of depression called *Dysthymia* and from *Bipolar Disorder*, previously called *Manic Depression*, in which episodes of depression alternate with episodes of mania. You even have a number, or rather, more accurately, your disease has a number: 296.33, where the first 3 after the decimal point indicates that it is recurrent and the second that it is severe.

Depressions are further characterized (not in the *DSM-IV*) as agitated or retarded. You probably have experience with both. In agitated depression, you are anxious, restless, filled with directionless energy you don't know what to do with and can't channel usefully. In retarded depression you slow down, just can't get mobilized, or are stuck in the molasses. In the course of a chronic depression one or the other predominates. They are somewhat different but equally awful.

Another distinction is between angry and empty depression. There is more anger, sometimes without much awareness of it, in the agitation and more emptiness in the retardation. Once again, you've probably experienced both: impotent rage and feeling like one of those that T. S. Eliot called "the hollow men, the straw men." Both are awful, but the feeling of hollowness, of having no good stuff, or worse, no stuff at all,

is, I think, harder to take than an angry depression. The experience of emptiness in an empty depression is puzzling. Is this purely neurochemical? Is it a representation of the impoverishment concomitant with deep depression? Is it a reflection of the inability to make meaningful emotional connections when you're deeply depressed so it feels like there's nothing inside? Or perhaps it's some combination of these. I would like to suggest yet another possibility. I think sometimes the feeling of emptiness in empty depression comes from the fact that what is present is sealed off, so to speak, under the basement floor, and what is under there is emotion of various sorts, particularly anger, indeed even rage. So if you experience an empty depression, do a self-probe and see if you come up with a lot of anger underneath the emptiness. You may very well do so, and of course you feel so empty because the prime emotion you're currently experiencing is not available being, as I said, underneath the floorboards.

Some of the more acute symptoms listed in the *DSM-IV* such as appetite loss and sleep disturbances are unfortunately usually integrated into chronic depression and they just linger, impoverishing your life and diminishing your vitality and capacity for joy. Therein lies the chronicity, along with the ever-present possibility of acuteness. There are many ways

to explain the chronicity. A now discarded one, although it held the field for hundreds of years, is what's called the *humour theory*, which accounted for differences in temperament by the balance or predominance of one of the four humours: blood, phlegm, cholera (yellow bile), and melancholy (black bile). So one could be sanguine (cheerful), choleric (that is angry), phlegmatic (calm), or melancholy (depressed). Your temperament and potential for being depressed are determined by the balance of humors you came into the world with.

It is worth noting that Galen, the second century Roman physician who first articulated the theory, believed that melancholy was a necessary ingredient (in proper balance) for physical and mental health. Modern views of temperament see it as largely genetically determined, and some temperaments do predispose to depression. Some have even proposed the existence of a built-in hapistat that is preset by one's genes to an equilibrium point on a happiness scale. Temperament does play a role in your susceptibility to depression, but the hapistat metaphor is too deterministic for my taste and it's just that, a metaphor.

Considerations of temperament bring to mind the author of *Ecclesiastes*—reputedly Solomon—who famously wrote “vanity of vanities, all is vanity.” Was he a melancholic, (i.e. a chronic depressive)

or was he a realist? Would he have written a different book if he had been on Zoloft or Prozac? Impossible to say, but it is noteworthy that the author of *Ecclesiastes* finds power, riches, wisdom and pleasure all empty because death takes the wise man no less than the fool, which suggests that one's attitude toward and beliefs about death are highly consequential determinants of one's propensity to depression. And of course the vector also goes the other way, depression strongly colors one's response to the finality of death.

Chapter 2: Treatment Options: Their Uses and Limitations

If you are reading this book, you probably know more than I do about treatments, having tried so many of them. Nevertheless, the summary of the tools available and some comments on them may prove useful. The good news is that we do indeed have better treatments, whatever their limitations, and research may well give us yet better ones.

Psychopharmacological Treatments

Let's start with the pharmacological. The oldest class of drugs used to treat depression is the amphetamines. These are stimulant drugs that increase the quantity of excitatory neurotransmitters in the synapses of some circuits in the brain. "Come again?" you say.

The cells of the nervous system—the neurons—including the brain, don't quite connect with each other. The gap between them is called the synapse. Chemicals—neurotransmitters—go across the gap and transmit information to the cell (the post-synaptic neuron in technical terms) across the gap. These chemicals can be uppers (excitatory) or downers

(inhibitory). All the antidepressants act on these neurotransmitters. The stimulant ones, like the amphetamines, pump out excitatory neurotransmitters from the presynaptic (before the synapse) neurons. Since the neurochemical correlate (maybe or maybe not the cause) of depression is diminished availability of excitatory neurotransmitters resulting in slowed down transmission of information in certain brain circuits, increasing the availability of these chemicals (neurotransmitters) is a perfectly logical treatment for depression. Stimulant drugs do indeed alleviate depression, so we have *the*, or at least *a*, cure—no? Unfortunately, no. Why not? The nervous system quickly habituates to drugs like amphetamines, necessitating raising the dose. At higher doses, they have all sorts of baleful side effects, including anxiety and jumpiness. A drug you need more and more of is an addictive drug. So these days psychopharmacological stimulants are rarely used alone in the treatment of depression. They are sometimes used to supplement other antidepressant drugs and you may have had them prescribed with that purpose. Sometimes their addition results in a treatment response when there was a weak one or none at all.

The psychostimulants have largely been supplemented by antidepressants. They work differently than the stimulants. Instead of

increasing the quantity of excitatory neurotransmitters, they prevent their reuptake. What does that mean? Well, once the excitatory chemical is in the synapse it would continue to jazz up the post-synaptic neuron forever and serve no useful purpose since it is the difference in the rate the neurons “fire” that conveys the information that it is the nervous system’s job to carry. “Fire” in this context means setting off an electrochemical reaction that acts as a signal. To prevent this, the neurotransmitter, so to speak, is sucked up back into the neuron before the synapse—*reuptake* is the technical term. One class of antidepressants slows this reuptake, making more excitatory transmitters available. Since depression is down and excitatory transmitters are up, they have the potential to lift depression.

There are several types of antidepressants. The oldest are called tricyclic because there are three rings in their molecules. Elavil is the most frequently prescribed tricyclic. It is quite effective, especially for severe, acute depression. Unfortunately, there is a price tag on everything and Elavil and its relatives have problems. The neurotransmitters antidepressants are supposed to work on are primarily serotonin and norepinephrine. The tricyclics unfortunately also act to depress a neurotransmitter called acetylcholine. This “anti-cholinergic effect” is

hard to live with, causing dry mouth, constipation, and sometimes urinary retention, among other things. These side effects are intensely uncomfortable and feel invasive. In common with other classes of antidepressants, the tricyclics can lose their effectiveness over time so they aren't much prescribed these days. They're usually used when other drugs don't work.

The most commonly prescribed antidepressants these days are SSRIs, that is, selective serotonin reuptake inhibitors, which increase the availability of the excitatory neurotransmitter serotonin in the synapse. SSRIs are called selective because they target particular neurotransmitters, usually serotonin, sometimes serotonin and norepinephrine while not affecting neurotransmitters like acetylcholine in ways that cause the unpleasant side effects that the older tricyclics did. The first of them was Prozac, a billion-dollar seller. One day I came home to have my wife tell me, "The doctor put Priscilla on Prozac." Priscilla was a German shepherd, who, so far as I could tell, was not in the least depressed. Oversold, perhaps, yet Prozac and its cousins helped many and still do help many people. Other commonly prescribed SSRIs include Zoloft and Cymbalta. Cymbalta differs from Prozac, Zoloft and, to name another popular one, Lexapro, in that it affects the reuptake of

norepinephrine as well as the reuptake of serotonin. In fact, it is believed to act primarily on norepinephrine. It is a drug worth trying if you've gotten minimal or no response from one of the serotonin reuptake blockers. It gives you another option.

What about the down side of the SSRIs? There are quite a few. They don't work for everyone or for all depressions; they often lose their effectiveness over time; they take roughly six to eight weeks to be fully operative; they commonly result in weight gain, particularly in women; and they can have sexual side effects. Women may have trouble getting aroused and have difficulty or find it impossible to orgasm. Men may have problems with achieving and maintaining an erection and/or in coming. When people are maximally depressed, they don't care much about sex, but if they get an antidepressant effect from their SSRI they do care and this becomes a not trivial side effect, leading to non-compliance, that is, going off the drug. The same phenomenon happens with weight gain. Additionally, some people are anxious or jumpy on SSRIs, especially when they first go on them. Most, but not all, accommodate and become less anxious.

What if you have a "treatment-resistant" depression that doesn't respond to stimulants or SSRIs and a trial on a tricyclic doesn't work

either? Well, there's yet another class of antidepressant that might be worth trying called MAO inhibitors. Incidentally, "treatment-resistant" is meant to refer to your depression, not to you, but it is often heard that way and unfortunately sometimes the frustrated prescriber unwittingly thinks of you as the agent resisting treatment. MAO inhibitor means monoamine oxidase inhibitor. When one of those excitatory neurotransmitters like serotonin are out in the synapse they are not only reuptaken, they are chemically degraded—rendered inoperative by chemicals, enzymes that are also in the synapse. They do their work by oxidizing the neurotransmitter, that is, they facilitate the combination of the neurotransmitter with oxygen, in effect burning it up. Those enzymes contain one amine group in their molecule, hence are called monoamine oxidases (MAOs). This type of antidepressant inhibits the action of the enzyme that degrades excitatory neurotransmitters, resulting in a greater availability of those excitatory neurotransmitters: serotonin, norepinephrine, or both.

MAO inhibitors are not often prescribed, and for good reason. They are dangerous. The person taking them must totally avoid a rather long list of foods, certain cheeses, for example, that contain amino acids that are acted on by the MAO inhibitors. Such interaction sends blood

pressure skyrocketing, thereby radically increasing the risk of a disabling or fatal stroke. If you've been on a MAO inhibitor, you know how careful you must be. To be on one would make a nervous wreck of me, but people on them have to be careful and serious complications are rare. Yet, if nothing else has worked, an MAO inhibitor is worth a try. As with all antidepressants, not everyone responds, effectiveness may lessen or cease over time, and there are probably side effects of which I am unaware. The most widely prescribed MAO inhibitor is Parnate.

Welbutrin is another antidepressant that doesn't fit easily into any class. It is a sort of entity unto itself. It, too, is a reuptake blocker. However, it blocks the reuptake of two neurotransmitters: norepinephrine and dopamine, a combination not targeted by other anti-depressants. Dopamine, which plays many roles in the nervous system, is the key neurotransmitter in the pleasure centers of the brain. It therefore makes sense that a treatment that increases the availability of dopamine, thereby further stimulating the pleasure centers, would be helpful to someone who is depressed. Welbutrin is most often prescribed in conjunction with another antidepressant. It has a number of advantages. It does not have sexual side effects and it does not promote weight gain. It does, however, make some people nervous, and like all antidepressants, it

is prone to failure, or at least radical diminution of its effectiveness over the course of time. As far as I know, it is not addictive. So Welbutrin offers another possibility for psychopharmacological treatment.

Psychiatrists, psychopharmacologists, and primary care physicians who are the ones that actually do much of the prescribing for depression often have to play with dosages and with competing SSRIs (these days, there's a slew of them) trying to find an effective treatment. This is more empirical than scientific, sort of trial and error, though there are rationalizations for using one rather than another of the SSRIs to treat a given symptom profile of a depression. However, they aren't very convincing. If you've been living with depression for a long time, you have probably gone through a lot of such juggling and you know how extraordinarily frustrating it can be. Nevertheless, it is most certainly worth playing around this way to try to get a response, especially if a drug that worked for you has ceased to do so.

There's yet one more psychopharmacological strategy for treating intolerable depression, that is adding an antipsychotic to the regimen. The heavily advertised drug Abilify is just such an antipsychotic. Sometimes this works, at least for a while. The down side of adding an antipsychotic is that there is some risk of developing tardive dyskinesia, an irreversible

movement disorder, especially if you stay on it for a long time or you are female. I'm not certain what the risk is, and it is probably fairly low, but unfortunately, there are other side effects of antipsychotics. Again, if nothing else has worked for you, the addition of a drug like Abilify may be worth a try. Although this is a book about unipolar depression (i.e., depression without manic episodes), I should mention a common and effective treatment for bipolar depression, lithium carbonate. It must be monitored carefully because lithium can cause kidney damage. The so-called mood stabilizers (originally developed as anti-seizure medications) such as Tegretol are also used in the treatment of bipolar disorder.

What do I conclude from all this? Psychopharmacology is good stuff, albeit oversold. Over the past generation it has offered hope to the hopeless and permitted many to recover from or mitigate their depression. But if you are reading this book, you are no longer one of those who radically benefits from psychopharmacology of your depression. Of course you don't know how much worse it could be if you were off your drug regimen, and new drugs keep coming down the pike. So my advice is to stay with whatever helps, however partially, and put yourself in the hands of a psychiatrist (if you aren't already there) who

assiduously keeps up with the latest advances in the chemical treatment of depression.

I should mention once again another bit of bad news. There's a phenomenon called "kindling" in which earlier depressions act as kindling for later depressive episodes, making them worse. So it is wise to do anything possible, including psychopharmacology, not only to attenuate present pain, but to mitigate the possibility of recurrence of severe episodes.

On the skeptical response side to antidepressants, there are several studies that show that cognitive psychotherapy of depression is at least as effective, if not more effective, than drugs for the treatment of mildly and moderately severe depression. These studies go back to one reported by the founder of cognitive therapy, Aaron Beck, twenty years ago. However, it is not so clear at this time if the more severe, chronic depression you suffer is better treated with some forms of psychotherapy than with medication. At this stage of the game, you're probably staying with medication because you have little to lose, but you are pretty damn frustrated because it isn't helping you all that much.

There is an association between alcohol use, especially alcohol abuse, and depression. Lots of people self-medicate depression with alcohol. It is the wrong antidepressant and only makes matters worse. Being an anesthetic, booze gives temporary relief from the pain of depression; being a central nervous system depressant, it actually exacerbates it. The use of stimulant drugs like cocaine is similarly futile. True, there is a pleasurable rush, but then a terrible crash. Don't be your own psychopharmacologist with "recreational" drugs. They won't help and just create a new problem. In the course of your chronic depression, you may have found this out for yourself.

Somatic Treatments

The somatic treatments we will consider here are of three types: electroconvulsive treatment (ECT), transcranial magnetic stimulation (TMS), and vagal nerve stimulators. ECT, colloquially referred to as "shock treatment," has a bad rep, and indeed is an invasive procedure with significant risk. It can also be a lifesaver in severe suicidal depression. The response to it is often dramatic. On psychiatric hospital wards, patients who one day were slumped into withdrawn, almost catatonic lumps, are seen after a few treatments walking around conversing cheerfully. So ECT has its uses. In the past it was often

misused to treat conditions it could not help, such as schizophrenia, and in assaultive ways for too-long courses of treatment, delivering too many shocks to the brain. This is no longer done. The ways it is administered have also evolved. Today, the shock is usually delivered to only one side of the brain and muscle relaxants and anesthetics eliminate such adverse effects as broken bones in the course of the ensuing convulsion. The most pernicious side effect, a troublesome, potential debilitating one, memory loss, is minimized. When using modern ECT protocols, not only is memory disturbance minimized, but recovery with restoration of normal cognitive functioning is far quicker. Having said this, ECT is still somewhat analogous to starting a stuck engine by banging on it with a hammer and a crude method for shaking things up and getting them working again.

You may have had ECT and hopefully it helped you. It is clearly useful in acute, dangerous, severe depression that does not respond to psychopharmacological treatment and is not accessible to talk therapy. When it works, it alleviates the worst symptoms. It is *not*, however, a cure for depression, which more often than not recurs. Additionally, memory loss, although this does not usually occur, can indeed persist. So ECT is a heroic treatment to be used only in situations calling for heroic

interventions. It has little or nothing to offer for the type of chronic depression we are discussing.

On the other hand, a newer treatment, Transcranial Magnetic Stimulation (TMS), may have something to offer you. Apparently it works somewhat like ECT while being minimally invasive. Instead of delivering a shock to the brain it infuses it with magnetic energy, a painless procedure that does not involve either loss of consciousness or loss of memory. To go back to my analogy, if ECT acts somewhat like the use of a hammer to jump start a stalled engine, TMS is more like shaking the engine while bathing it in warm water.

TMS's effectiveness is not well established; empirical evidence supporting its use in the treatment of depression is weak. However, I do know two psychiatrists I greatly respect who report some striking successes with hitherto intractable depression using this method. That doesn't mean it works for everybody or that it would work for you.

There are some down sides. It is a time-intensive treatment requiring four sessions of approximately two hours, four days a week, for six weeks, and in all probability a reduced maintenance schedule thereafter. It is expensive. Insurance companies tend to be highly resistant to paying

for TMS, but after a protracted struggle, some of them do. If nothing else has helped you, TMS is worth investigating.

Vagus nerve stimulators were developed at Duke University as a treatment for intractable depression. The vagus nerve carries messages to and from the brain to a wide variety of internal organs, stimulating smooth muscle. It does so in the stomach, for example, and also plays a major role in regulating the heart. In this treatment a pacemaker type of device is implanted in the neck to send a message up to the brain, stimulating certain brain circuits. The initial results were promising. The stimulator was surgically implanted, the device regulating the frequency and pattern of stimulation of the vagus nerve adjusted, and some extremely depressed people were responsive. I don't know how this treatment has stood the test of time, but once again, if all other treatments have failed you, vagal stimulation is worth investigating.

Psychotherapeutic Treatments

Let's take a look at the psychotherapeutic possibilities. They fall into three broad categories: psychodynamic, cognitive, and interpersonal, and each has an etiological subtext. That is, the treatment is intrinsically intertwined with a theory about causality. As a therapist, if you believe

that depression is caused by genetically transmitted vulnerability to less than optimal neurotransmitter balance and function, then you would treat psychopharmacologically to redress the balance. That is what psychopharmacologists do. As a therapist, if you believe that this is only partly true and that this vulnerability only becomes manifest after traumatization, then you would prescribe psychopharmacology and psychotherapy. If you believe that depression is powerfully triggered by loss, by overidentification with and internalization of the lost object, by anger turned against the self, and by events precipitating massive loss of self-esteem, you would engage in psychodynamic psychotherapy. If you as a therapist believe that depression is a result of irrational thinking, then you would prescribe cognitive therapy, and if you as a therapist believe that the cause of depression, or at least the cause of the depression continuing, is disturbed relationships with other people in the present, then you would prescribe interpersonal psychotherapy. Although there are more extreme advocates who claim exclusivity for their particular approach, the truth is that they are not mutually exclusive.

There is an historical dimension here as well. If we asked a medieval or Renaissance physician, he would cite the imbalance of the humours, discussed above, with the predominance of one of them (black bile) being

the cause of melancholia. We moderns have a different metaphor. Instead of speaking of the humors, we talk about the neurotransmitters. If you think about it, the two aren't all that different. Perhaps instead of describing people and their personalities as sanguine or phlegmatic, terms derived from the humour theory, we will start describing people as serotonic or norepinephric, a gain for science but a loss for poetry.

Clearly we have too many causes here, leading us somewhere between the blind man and the elephant and "Dear Officer Krupke." Amazingly, they can all be true, applied to different people and different types of depression and/or the same person in different phases of depression. We human beings have neurotransmitters and we have relationships. We have memories and we process current reality. We have genetically transmitted structures and patterns and we suffer loss and trauma. All of these factors interact. To cite a rather sad example, trauma alters neurochemistry for the worse so that trauma is doubly registered as memory and as altered brain function. So an openness by both therapists and sufferers to a multiplicity of treatment approaches makes the best sense. As a victim of chronic depression, you know that none of the above have completely done the trick for you, even if they

have helped. Yet they probably haven't been totally useless. Or perhaps, sadly, they have been.

The Psychodynamic Approach

Let's start with the psychodynamic approach. Here, too, there is a range of approaches from the classical psychoanalytic five times a week on the couch to once a week face-to-face meetings. Psychodynamic treatment for depression generally is once or twice a week face to face. Sigmund Freud wrote a great paper, "Mourning and Melancholia," which has shaped the analytic-dynamic treatment of depression ever since. In it he contrasts a normal phenomenon, mourning, with a pathological one, melancholia, which we call depression. In both he hypothesizes there has been a loss (of a person or an ideal or a job or a valued place in the world) resulting in little or no interest in the outside world. There is diminution of the capacity to love and painful affect. In mourning, what is lost is painfully conscious; in melancholia it often is not. In most cases of melancholia it is a mystery to both sufferer and observer what is being mourned, while it is obvious to all that the melancholic is mourning something. In Freud's account of it "successful" mourning requires intensely emotionally recalling memory after memory of the deceased until the photo album, so to speak, is exhausted. Mourning differs from

melancholia in that the mourner, as well as the observers, knows perfectly well what loss is being mourned. The intensity of the emotional connection to each memory breaks that emotional bond, somewhat like stretching a rubber band beyond its capacity snaps it. Just as the snapping rubber band inflicts pain as it recoils, the hyperemotional memory inflicts pain as it snaps. The end of a long process, the last tie—the final memory—is snapped, and mourning comes to an end. Reality has won, the loved one is no longer here, and reason dictates that we move on. But it's been a hard fight, absorbing all of the mourner's energy as he or she engages in what Freud called “the mourning work.”

Melancholia is different. Not only is what has been lost mysterious, but the process is baffling as well. Depressions are characterized in many ways. One of the most familiar and useful distinctions is between endogenous and exogenous depression. If someone tells you that he is deeply depressed, goes on to say that he has been fired, diagnosed with HIV, and his wife ran off with his best friend, we are not puzzled about his being depressed. This is an exogenous depression. On the other hand, if someone tells us she was walking home from work and started sobbing uncontrollably for no apparent reason, is only able to get home with tremendous effort, has felt helpless and hopeless ever since, and keeps

telling herself what an evil, worthless person she is, this is an endogenous depression and we are at a loss to understand or explain it. Chronic depressions are most often a mix, with the endogenous element predominating.

Mourning comes to an end (normally) while melancholia (at least in the form of chronic depression) does not. Further, the melancholic suffers a precipitous loss of self-esteem not present in the mourner. Further, as you know all too well, a depressed (melancholic) person reviles him- or herself with the most vicious self-accusations. True, the mourner experiencing “survivor guilt” does something of the same thing. But if the mourner’s self-accusations persist, going beyond a certain point, he is no longer simply mourning: he is depressed.

Freud tells us in a strange poetic way that in melancholia “the shadow of the object fell on the ego.” What does this mean? Well, to start with “ego” here means self and the object is what is lost: a loved one, an ideal, status, whatever. But the melancholic, the depressed one, has poor boundaries, so the lost object and the self get confused and indeed the lost one is now part of the self. The internalization of the lost object in this process is totally or largely unconscious. In Freud’s language, “an object relation” (that is one between two separate people) becomes an

“identification” (that is, now there is only one person, the self fused with the other). That’s bad enough, but things get worse. The lost loved one is experienced as having abandoned the self and there is rage at that abandonment. Since the self and object are fused, rage against the abandoning other or abandoning value becomes rage against the self. That is one mechanism explaining depression as anger turned against the self. What follows are the terribly tormenting self-accusations you know only too well.

Freud has much of this right. There is indeed an intimate relationship between mourning and melancholia-depression. In fact, some have hypothesized that one cause of depression is failure to mourn. This is congruent with my clinical experience. An important psychodynamic treatment of depression is facilitating belated mourning for old losses. Painful as that process is, it helps. Psychodynamic treatment does in general pay more attention to past wounds than other treatment modalities. This is never mere history; the past is only of therapeutic interest if it continues to influence the present, for example, by fueling depression. Since the unmourned losses are largely unconscious, dynamic psychotherapy works to make them conscious. This form of treatment also addresses the blurred or fused unconscious boundaries and seeks to

make them both conscious and more focused and distinct. Rendering anger more conscious and getting it out front, rather than turned against the self, is an important part of this process.

Psychodynamic treatment also puts loss of self-esteem into strong focus and works to raise it. Analysts who followed Freud emphasized this loss of self-esteem as a central dynamic in depression and zero in on it in their treatments.

Trauma is also central in the etiology of depression. So psychodynamic therapists, who are used to taking into account the influence of the past on the present, naturally turn to old, perhaps unconscious, trauma and try to bring it into the present so it can be worked through. The relationship between trauma and depression is complex. Depression is a symptom of trauma; repressed, unaddressed trauma causes depression; and depression is itself traumatizing. I shall return to the role of trauma in depression in the next chapter on the rehabilitation approach when I elaborate on the centrality of memory in mourning chronic depression.

A unique aspect of psychodynamic therapy is that it utilizes the relationship between patient and therapist, or in technical terms, the

transference and countertransference, to re-create the conflicts that brought the patient to treatment and, so to speak, bring them into the room. In that way, the past becomes the present and can be reworked and re-experienced.

Disagreeing with the cognitive therapists, Freud argued that melancholics' self-accusations were only apparently irrational; in fact, they contained more than a grain of truth. So arguing with the depressed one that his or her thoughts are irrational, which he knows isn't true, would only make matters worse. Here the clash between the two schools couldn't be clearer. Can they both be right? I doubt it, but maybe there is a time to confront and a time to confirm.

Freud also pointed out that the depressive's worldview, at least until it becomes overtly delusional, may well be more congruent with reality than that of the normal person. The only problem is that it is unlivable. We need a little Pollyanna to survive with a modicum of happiness, and, as you know, chronic depression isn't exactly Pollyannaish.

Many psychodynamic therapists believe that sadness is an effective treatment for depression so they try to get their patients to stay with their conscious sadness in therapeutic doses. I heartily endorse this.

Psychodynamic therapists also look at the possible defensive purposes of depression—is it a place to hide out—a security operation? This can sound accusatory and elicit an angry response, yet it is worth looking at to see if any such dynamic contributes to your depression.

Freud thought that the most recalcitrant force driving chronicity was the sufferer's belief that he or she doesn't deserve to recover, and that the painful symptoms are just punishment for sins real or imagined. Depression is a perfect whip for such self-flagellation; ironically (and tragically) depression can serve as a punishment for being depressed. Contemporary psychodynamic practitioners explore the ways in which conscious and unconscious guilt perpetuates the illness. This is another dynamic worth looking at. Irrational guilt is so much a part of depression as both cause and effect that it may very well be contributing to your misery.

To summarize psychodynamic treatment of depression: it focuses on making unconscious loss conscious; unconscious trauma conscious; firming up boundaries, conscious and unconscious, between self and other; raising self-esteem; and getting anger and aggression out front.

Cognitive Therapy

Cognitive therapy takes a different tack. Aaron Beck and Albert Ellis are the big names here. It has little, if any, interest in the past or in the reasons the patient became depressed. Rather, the whole focus of the treatment is on the irrational, unrealistic beliefs that keep the depressed person depressed, for example, the belief that he is the worst person in the world, or that she is worthless, or that only getting by getting straight A's will she be lovable. Cognitive therapy challenges these clearly counterfactual beliefs, some of them self-accusations, some of them unreasonable, unfulfillable expectations. Its tools are confrontation, demonstration (of irrationality), and reeducation. Cognitive therapy importantly expands the depressed person's experience of the possible. It is all about getting out of the self-imposed trap that constrictive, distorted thinking imposes. For example, the cognitive therapist would challenge the chronically depressed person's belief that things are hopeless, that the only light at the end of the tunnel is the locomotive. On the contrary, there are possibilities that the depression has blinded the depressed one to. In our example, you could lie flat on the center of the tracks, let the locomotive pass over you, or climb the ladder on the wall depression had blinded you to while the train passes, and then walk out of the tunnel. Or

to change the example, you might be convinced that girls with B+ averages find love too, and thereby lose your main reason for being depressed.

The concept of learned helplessness as an explanation for depression isn't primarily cognitive but is related. In a famous experiment Martin Seligman placed dogs on a floor that could be electrified. When the shock was turned on the dogs were able to jump over a barrier and escape. When they relaxed in apparent safety, Seligman shocked them again. They then jumped back to the other side and were shocked again. Then they gave up and just sat there and whimpered. Then the conditions changed. There was no shock on the other side of the barrier and they could escape their pain. But they didn't even try. They had acquired what Seligman called "learned helplessness," which he argued was an analog of human depression. Damned if you do and damned if you don't, so why try? Seligman then had an assistant drag the dogs over the barrier to safety, then return them to the shock side. It took ten interventions before the dogs spontaneously jumped over the barrier to escape the shock and arrive at a safe place. From this Seligman argued that therapists treating depressed patients need to be highly active, dragging those dogs to safety and demonstrating that the possibility does indeed exist. Cognitive

therapists are extremely active; they do it verbally and symbolically but they too drag those dogs over the barrier to safety.

Cognitive therapy has a very good record in treating acute depression. But its efficacy in treating the kind of depression you suffer is much less certain, indeed, highly questionable. Nevertheless, if you have no experience of cognitive therapy you have nothing to lose by trying it.

Interpersonal Therapy

Interpersonal psychotherapy also works with the present, but rather than trying to modify irrational beliefs, it examines and tries to modify the multidirectional interactions between the depressed person and his or her significant others. It postulates negative feedback loops that perpetuate or exacerbate the depression. For example, the depressed person infuriates his loved ones, who are, in effect, his caretakers, by refusing to take his antidepressant medications. They yell at him and call him a stubborn fool who is sabotaging himself despite them, all of which may be true. Their accusations confirm his self-accusations and make him feel even more hopeless, leaving him with no reason to take the meds. By now he's sure he's hopeless and that they won't help anyway, and besides, he can at least get a mini-jolly by upsetting mother and

father. They, in turn, get even angrier and their accusations grow nastier. Round and round we go in an ever-declining spiral. The interpersonal therapist seeks to disrupt this negative feedback system by making it conscious through interpretation, confrontation, and demonstration, let us say by role-playing of alternate ways of communicating.

In interpersonal psychotherapy, the past is not completely ignored. These counterproductive interactive feedback loops no doubt were operative at some level before the depression occurred and to some extent were etiological in its coming to be. That, too, can be interpreted, made conscious, and worked through.

If your family is anything like the family I described above, an interpersonal therapist might be just the ticket. He or she probably won't cure your depression but could help mitigate the factors and communication systems that are exacerbating it. Often interpersonal therapy is most effective in dealing with the secondary consequences of the depression and less so, at least in the kind of chronic depression we're talking about here, in curing the depression itself. It nevertheless brings a powerful new lens to the understanding of any particular depression.

Back to Ron Smith

How did this apply to Dr. Ron Smith whom we met in the last chapter? The psychodynamic therapist would view his or her first task as the establishment of rapport. Building the *relationship* between patient and therapist and using it therapeutically is at the core of psychodynamic treatment. Of course all therapists need to establish rapport with their client-patients, but the psychodynamic approach puts the relationship at the center of the treatment. How is this accomplished? Essentially by empathic, attentive, non-judgmental listening and engagement, by what the counseling theorist Carl Rogers called “unconditional positive regard.” This would be particularly salient working with Ron Smith, who is so filled with shame and has experienced so many high-volume condemnations, especially, but not only, after his breakdown. The therapeutic alliance between patient and therapist provides *safety*, hopefully a sufficiently secure sense that the therapist’s office is a safe place for the patient, here Dr. Smith. This feeling of being in a safe place makes it possible for the patient to experience and share extremely painful memories and equally painful stuff occurring in the present. The whole idea is to open things up, thereby opening up Ron and relieving the constriction that became so emotionally disabling after he descended into

the depressive pit. Along the same lines, Ron suffered horribly from isolation, aloneness, and loneliness, as well as feelings of not being part of the human race. Establishing a strong therapeutic alliance provides a form of community and Ron's experience is no longer solely that of a loner.

In the psychodynamic approach the relationship is used in yet another way. In the course of time, many of Ron's conflicts would be enacted in the therapy and his maladaptive defenses made manifest. This could be commented on (interpreted) by the therapist and worked on. For example, Ron exacerbates his loneliness by pushing people away and/or avoiding them. An instance would be his not responding to holiday greetings from old army buddies. The therapist would certainly call this to his attention, but better yet, Ron might enact his avoidance behavior, motivated by fear and shame, by missing the session immediately after a particularly emotionally connective one. The technical term for this reenactment is *transference*. The therapist would interpret the transference something like this: "Ron, you told me that you were feeling close to me after I connected with your despair during your breakdown in our last session two weeks ago. Then you didn't call and didn't show last week. I think there's a connection there. You're so hungry for some human

understanding. Yet when you get it you flee. That's worth talking about.” After such an intervention, all kinds of things—feelings—might open up, like Ron's wish for yet fear of closeness and the feelings of worthlessness and shame that make him flee.

The psychodynamic approach deals more with the past than the other approaches do, although it certainly doesn't neglect the present. It is particularly interested in trauma and loss. We know that depression is a symptom of trauma and that depression itself further traumatizes. And we know that ancient traumas, long secreted away from consciousness, can continue to depress. Of course loss can be traumatic and often is the central trauma in people's lives. The psychodynamic approach isn't interested in the past as history; it *is* interested in the past when it continues to influence or even determines the present. The psychodynamic therapist seeks to increase conscious awareness using all of the tools available. One such tool is dream interpretation. Patients are encouraged to report and explore their dreams, hopefully opening up new avenues of awareness. Depression itself powerfully influences what and how we dream. Just as depression can constrict conscious life, it can also impoverish and constrict the unconscious life expressed in dreams. At

first Ron Smith reported few dreams. It was only over a period of years that his dream life became available for us to work with.

The psychodynamic therapist would at one point challenge, or at least probe, Ron's reportedly happy childhood. There was just too much disturbance in his family: witness the suicide of one sibling and the drug overdose death of another for that to be entirely credible. Depressed people are often accused of "seeing through a glass darkly," retrospectively distorting and/or exaggerating their negative experiences, particularly their childhood ones. There is some empirical evidence that this is true. Nevertheless, my experience is rather the opposite, namely that people who suffer chronic depression engage in what I call *retrospective idealization*. Actually the proclivity towards distortion of memory works both ways, perhaps exaggerating the horrors of the past while paradoxically just as frequently repainting it with rose-colored paint. Psychodynamic therapists, including me, would be suspicious of those who see through rose-colored glasses. The reason all of this is important is that confronting real historical pain can indeed lighten or ameliorate depression. Ron's depression was softened by our reimagining his childhood in more realistic and darker terms.

There is also evidence that “depressives,” at least up to a point, actually see the world more accurately than the non-depressed. There was a bumper sticker around a few years ago that read, “Shit, more shit, then you die.” This does indeed encapsulate one aspect of reality, one that really exists and that the depressed person focuses on. Of course that’s not the whole story.

Back to Ron. It may be that before his breakdown his hapistat—that hypothetical entity some theorists think is “preset” to an equilibrium point by heredity—was naturally high, giving him immunity to whatever in his childhood home doomed his two siblings. But I doubt it. There was simply too much depression in the family and Ron’s long history of depression has to be connected to some pretty grim stuff early in his life.

Our hypothetical psychodynamic therapist would certainly want to know about those childhood enemas and the feelings and fantasies associated with them. My guess is that they were traumatic and that the adolescent self-administered enema was an attempt to master that trauma by reliving it, turning a passive experience into an active one. Such an interpretation, typical of dynamic therapy, would serve to normalize or at last explain the source of shame and self-loathing, thereby softening one

of the consistent and most punishing elements of Ron's depression. I could go on, but you get the idea.

Cognitive therapy stays in the present. Cognitive therapists would confront, challenge, and demonstrate the irrationality of many of Ron's present beliefs, beliefs that had gotten him depressed and are keeping him there, for example, his conviction that he is "worthless" or that his life has been a "complete waste." The cognitive therapist would try to convince Ron that such beliefs are counterfactual, at variance with reality. Take worthlessness. "Were you worthless when you were helping your outpatients in the army? How about the help you gave the inpatients before you got sick? What about the way you supported your mother during her declining years? How about the courage you showed when you repeated your first year of graduate school and went on to a doctorate?" Ron would no doubt argue, but the cognitive therapist would keep at it. "You generalize, distorting reality. Your life hasn't been a complete waste—look at the things you've accomplished. You yourself told me that you were a good therapist. How about that?"

The therapist might go on: "If you broke your leg and couldn't run a four-minute mile because of that, would you hate yourself? Depression is a disease and its effect on you is much like an injury. Just like the broken

leg would slow you down, depression does the same thing. To blame yourself for being sick—for having a disease—is irrational. It makes things worse than they have to be.”

Cognitive therapists also assign homework, teach coping strategies, encourage action, educate about depression and its causes, and persistently, gently, and determinedly challenge the irrational thoughts maintaining the depression. They use techniques like “thought-stopping,” that is, instructing a patient to “talk back” to the inner voice telling him he’s worthless, literally saying “shut up, leave me alone,” role-playing non-depressed behaviors, and suggesting other ways of thinking. It all helps. Unfortunately, it’s most helpful in acute depression. Still, it has something to offer in chronic depression. If it “only” loosens one obsessive self-hating thought, it has done something significant. Then you would be, to some extent, less deeply depressed.

The interpersonal approach encourages examining here-and-now interactions with other people that contribute to maintain depression. If Ron had consulted an interpersonal therapist during the period when he was having his breakdown, the therapist would have zeroed in on his relationships with his commanding officer, with his peers, with other hospital personnel, and with his patients. What sort of negative feedback

loops were operating? For example, as Ron started feeling depressed he chose to work with the sickest patients, who frequently confirmed his growing belief that he was inadequate at best and useless at worst as a therapist. His already very sick patients then being treated by a self-doubting depressed psychologist would be even less likely to improve, confirming Ron's belief that he was useless. Panic was not far behind.

The interpersonal therapist would make manifest this negative feedback loop and seek to disrupt it, perhaps by telling Ron that he needed to work with patients with better prognoses if he wanted to feel better, and then help him work through these fears of being inadequate with higher functioning patients so he could get some positive feedback.

Interpersonal therapy looks at the internalized feedback loops, the interpersonally destructive tapes imprinted by past experience that both cause and maintain depression. But its focus is on the present, including the interplay with the therapist. If Ron had consulted an interpersonal therapist after he returned home from the service and was subjected to relentless criticism for "laziness and malingering," the therapist might have suggested family therapy and helping Ron see the angry, "passive-aggressive" component of his nonfunctioning, while helping the family to see that they were just making things worse by berating Ron and telling

them that if they backed off he might do better. Their rage at Ron's disease had become rage at him, and if they could see that dynamic, some improvement might have been possible.

All three psychotherapeutic approaches have their uses. All of them are helpful with the right patient at the right time. None of them "cure" chronic depression, although they may make it more tolerable. I believe that regardless of "school" or "technique," the most important predictor of therapeutic success is the relationship. I advise you to be in therapy; it helps, even if it doesn't cure. So don't give up. There is some professional out there who can be a force for good in your life and that is worth having. Depression is a bio-social-psychological phenomenon. Biological vulnerability, inborn or acquired through traumatization, including the traumatization of major depression itself, interacts with the social surround that often contributes depressive forces, perhaps in response to the depressed one's behavior, such as rejection, unrealistic expectations and demands, and lacerating criticism, which in turn interact with internal saboteurs, self-hating self-concepts, and overidentification with now gone and/or malignant people in the sufferer's present or past life. All of these continually reinforce each other, resulting in either continuing plunging into the darkness or keeping you stuck there. No

wonder you feel awful. You just can't find anything that you can do to make it better. Any decent treatment of chronic depression addresses each and every contributing factor enumerated above with appropriate means: pharmacological, somatic, social, and psychological.

Chapter 3: The Rehabilitation Approach

This is a short chapter that I hope will have a powerful impact. You have been and are suffering from chronic depression. Chronic depression is a *disability*. If you had pneumonia and recovered, we would not say that you suffer from a chronic illness or that you are disabled. On the other hand, if you develop obstructive pulmonary syndrome, we would say that you suffer from a chronic illness and that you are disabled by it and that would be true. It is similar with depression. If you suffer from acute depression, however severe, and recover, common sense would say that you have been ill and now you are well, and that would be the case. Chronic depression isn't like that. Though it may give you intervals of remission, it just doesn't go away. It pervades your life, affects your moods, your vocation, your bodily health, and your relationships.

Having chronic depression does *not* mean that you are actively depressed every moment of your life. You even may have moments of joy, and at times have strong interests and be highly emotionally invested in various activities and relationships. What it does mean, and this is the bad news, is that a great deal of the time you are sub-par and at times feel

just plain awful. Even during good stretches, there's that terrifying dread of going back into a black hole. Worse yet, that can really happen. If living with such a constellation of woe doesn't constitute a disability, I don't know what does.

It's not easy to hear that you are disabled, that you have a disability that however well you manage it, is going to follow you like a shadow. That is indeed bad news whatever way you look at it. But there is some good news. Recognizing the daunting fact that you are disabled opens up possibilities of coming to terms with that disability and coping with it in ways hitherto you've not even imagined. Unfortunately, this is not a case of the truth making you free, but the truth does to some, maybe even a considerable, extent, free you up. This is a chapter whose aim is to help you face the truth about your condition and to suggest ways to come to terms with it, ways to minimize its impact on your life.

As we have seen, chronic depression has many causes, among them your temperament. Some temperaments predispose to depression. If you're on the obsessive side, that also predisposes to depression. You didn't choose your temperament, which is largely a genetic given. Then there are your genetically determined neurotransmitters. You didn't choose them either. There are also the powerful effects of both early and

current trauma. Trauma is cumulative. It can pile up to a breaking point. And as we've noted, depression itself is traumatizing. Trauma is recorded not only in memory, but as altered brain structure and function. You didn't choose any of that either. Realizing and coming to truly *believe* that you didn't cause your disability—your ongoing depression—has the potential to alleviate at least some of the torment and guilt so intrinsic to depression. Now you don't have to feel guilty about being sick, that is, about being depressed—although you have long felt such guilt, which can be truly tormenting—any more than you could justifiably feel guilty about being paralyzed from polio. You *aren't* responsible for your depression; you *are* responsible for treating it to the max and coping as well as you can with the untreatable residue.

Taking action is one of the best antidepressants. It breaks the feelings of hopelessness and helplessness so intrinsic to the disease. Doing all you can to treat your illness and taking steps to cope with the part that is not amenable to treatment is taking action—taking a strong action. It will definitely help soften those horrible feelings of helplessness and hopelessness.

You may have had difficulty identifying with Ron Smith, whose depression was so radically impoverishing. You are about to meet two

people whose depressions are no less chronic, yet have permitted them fuller lives in which vocational accomplishment and satisfying relationships have been possible. It is likely that you will find it easier to identify with them.

Margaret

I had known Margaret for many years. The most recent exacerbation of her chronic depression was truly horrific. It recalled the tormented young woman I met so many years ago. She came to me unemployed, undereducated, and desperate. She manifested those twin signs of depression I just suggested that action ameliorates: feelings of helplessness and hopelessness. Margaret's childhood had been bleak at best. Her father drank heavily and was extremely nasty, angry, and bitter when in his cups. Rationalizing that he had always been employed and was a "good provider," he concluded that he could do whatever he pleased after business hours. Her mother was depressed more often than not and there was alcoholism as well as widely dispersed depression on both sides of her family. During the early years of our relationship Margaret was often frozen in fear. Her demeanor was that of one who was terrorized. In the course of our work she got in touch with a traumatic memory of the night her drunken father had violated her. She

was six. At an unconscious level she “knew” that she had entered therapy to bring to consciousness her sexual abuse by her father. That was the source of her terror. She believed that he “would know” that she had told and would kill her. That, of course, was a displacement of the terror in response to her father’s threats when she was six. Margaret was in no way psychotic; yet her conviction that her now elderly, sick, rather pathetic father would “know” and kill her was close to crazy. Once her trauma was conscious we worked with all its associated emotions: sorrow, fear, rage, powerlessness, shame, and paradoxically, as is common in those abused as children, guilt. That work helped, and months of emotional catharsis seemed to pay off. Yet her terror remained. Then we got a break. Her father suddenly died, which was transforming. Margaret not only felt better, she looked different. She even smiled from time to time.

Her parents fought continuously, yet another traumatization, and her mother, her only refuge, started drinking herself, and at one point abandoned the family, driving off in a rage. She returned several weeks later, but that didn’t undo the terror of being alone with the drunken father. Her three older siblings, all boys, had left by then. Neither in childhood nor down to the present had the children been close.

By some miracle, Margaret managed to marry a decent man who loved her, as she does him. Her marriage is the best thing in her life. Margaret sort of had two mothers: a sober, kind, supportive one, and a drunken, depressed, abandoning one. I told her that she had been lucky enough to marry her “good mother” and she agreed. In normal development children generally fuse and integrate their experiences of bad and good mother; this is part of healthy maturation. However in the pathological environment Margaret grew up in, such a course would have deprived her of a good parent, for the good mother would have been so contaminated by the bad mother as to have been useless to her. Fortunately, she was able to keep the two apart in her mind—all of this on an unconscious level—and to refind the good mother in her husband.

Margaret had long self-medicated her depression with amphetamines, which gave temporary relief, only to exacerbate her condition when she crashed. She may also have altered her brain chemistry, making it more susceptible to subsequent acute depressions. It took her a long time to trust me enough to tell me about her chronic use of “uppers.” She had a hell of a time going off them but she succeeded, and with the help of a psychiatrist who prescribed the appropriate antidepressant medication,

she weathered her withdrawal surprisingly well, hellish though it was. It is now many years since she has used drugs.

Over the next few years, Margaret seemed to have worked through the multiple traumas of her childhood. She found a job in the purchasing department of a local university and studied at a community college, receiving her associate degree with honors. She was no longer depressed, nor was she living in terror. When she terminated therapy, I thought I had a cure. I was wrong.

Margaret has since suffered repeated episodes of depression of varying severity. The last was the worst. Making the best use she could of her depression-free, or relatively free interludes, Margaret made a career for herself at the university. Switching departments, she progressed into a responsible, well-paying, middle-management position, and she has experienced some joy. She developed a passion for gardening, which gives pleasure and meaning to her life. Unfortunately, this interest dies when the depressions are at their worst.

Margaret returned for ongoing psychotherapy several years after her termination and that has been sustaining. She has also had good fortune in working with a creative psychiatrist who cares about her, always

scrambling to find a new combination of meds that would be effective when the old ones failed.

To return to Margaret's most recent episode of acute depression: it was triggered by a change in upper management in her department. After feeling proud and autonomous on the job, her new micromanaging boss undermined all she had gained. Constantly criticized, controlled, and made to feel inadequate, she became filled with rage and shame. She grew more and more depressed, finally going out on disability.

The loss of status, purpose, and source of self-worth was devastating for her. She blamed herself in spades. She was fearful of running into people she had known on the job. Shame and guilt became her constant companions. Not for the first time, Margaret seriously contemplated suicide.

Suicide frequently becomes a serious option for the chronically depressed. It probably has for you. Should you commit suicide? I can't decide that for you, but I do have some thoughts about it. Suicide is attractive as an escape from suffering; it is often an expression of almost infinite rage, and it can be a consequence of the distorted thinking caused by the disease itself. Let's look at these in more detail.

Euthanasia as an escape from hopeless, unendurable physical suffering is increasingly acceptable and in fact it is legal in some states. Some have argued that the pain of intractable depression is parallel to such bodily suffering and ending it by taking one's life—with or without assistance—should be an available option. I don't disagree. However, chronic depression is different from terminal cancer. First, there are now new and better treatments being developed and hope of at least partial recovery is not unrealistic, as it well might be in the case of terminal cancer. The severity of depression varies, going up and down, so making an irreversible decision during an episode of exacerbation needs to be extensively questioned. The possibility isn't going to be taken away from you, so there's no need to act now. Think it through. Then think it through again.

Then there is suicide as an expression of rage. Fuck 'em all. Margaret certainly had an unconscious target in her boss when she was thinking of ending it. Rage of which you are unconscious is not a good or adequate reason to kill yourself. So ask yourself, being as honest as possible, if you would be “suiciding” *at* somebody. Preferably do that exploration with a therapist. As you know, depression can be viewed as anger turned inward, and getting in contact with unconscious, internalized rage may

save your life. There are better ways of getting revenge than killing yourself. Besides, it isn't very effective. In all probability, your intended target—conscious or unconscious—will be little affected by your choice and will soon forget all about you.

You do need to factor in the likelihood that your depression is distorting your thinking. Again, it's a good time to talk it over with someone like a competent therapist. Finally, there is suicide motivated by sheer exhaustion. "I just can't do this anymore. It's going on for too long." This one is really dangerous. Nobody can tell you whether or not your struggle is worth it, but the likelihood is that it is. Again, think it through and talk it over.

Margaret is enraged. Mostly she is enraged at her depression itself. "This fucking thing has made my whole life a struggle." It certainly has. And you too have every right to be furious at the fate that gave you your predisposition to depression. Margaret is also angry at the people who traumatized her, but she is much less so than she used to be. She tells me, "It isn't the childhood stuff anymore. I've pretty much worked that through during the many years of therapy with you. I've even forgiven my parents for the things they did, if not for the genes they gave me." This is mostly true. She is now fully conscious of the anger she feels at

her last boss, whose sadistic behavior triggered her current depression. The more she feels her anger, the less her shame and guilt. Our work in making her anger conscious and the opportunity to express it in therapy has paid off. Kindling, discussed above, has certainly contributed to both the presence and severity of her latest episode. The danger of kindling doing its sub rosa terrible work is an excellent reason to stay on medication and in therapy. Fortunately, there is a countervailing force to kindling. There is substantial empirical evidence that people tend to be happier as they grow older. Some, maybe most, of the *sturm und drang* of life is past, and people often grow to accept and enjoy the place where they have arrived.

I don't know if this applies to advanced old age, but it does seem to characterize late middle and early old age. Does this apply to those, like you, who suffer chronic depression? We don't know. There are no research studies in this area. But it may. Our friend, Dr. Ron Smith, is a case in point. He is happier now, late in his life, than he has ever been. In spite of the wasted years consequent upon his disease, he is mostly content. Is this the manifestation of his depression "burning out"? Is there such a thing? I don't think we know, but perhaps.

In spite of recurring suicidal thoughts, Margaret has not given up. She is readjusting her meds once again; she is continuing in therapy; and she is exploring the possibility of TMS (transcranial magnetic stimulation).

George

George is a sculptor. His depression is also lifelong, but much less unremitting. He has had long periods of relative normality during which he is free of major depression, if not entirely free of the less ominous dysthymia. His depressions have been intertwined with heavy drinking, which has been both cause and consequence of it. That is, his depression has been gravely exacerbated by his drinking, even as his depression has triggered futile attempts to ameliorate it with alcohol. George has been sober and an active member of A.A. for several years, and he is much less depressed.

George's mother was a severely depressed woman who withdrew from life and lived out essentially inert, hopeless years, waiting to die. His father was little present and chiefly involved in running his farm. George's deepest fear is becoming like his mother. His was a lonely childhood. His best and almost only friend was his brother. When they were both in their early twenties Larry was killed in a hunting accident.

Larry had been the father's favorite and the father, too, fell into a profound depression after the death of his son. George never really recovered from these twin losses. His father, as little present as he had been, was the more available of the two parents and he was no longer really there, and of course Larry was dead.

Loss in general and unresolved or incomplete mourning are major dynamics in depression, and much of my work with George is focused on helping him mourn his brother. You can't mourn behind an addiction and George anesthetized the pain of his loss with alcohol without resolving anything as he grew ever more depressed. As he was able to do some mourning in our therapeutic work together, his depression to some extent lifted. At another point in our work when George was in one of his lows, I reflected that he was in a really awful place. He got angry and pushed back, snapping, "Not awful, uncomfortable." And then he smiled. That was a turning point in dealing with that particular depressive episode. George's getting angry really helped. A high school art teacher recognized his talent and George won a scholarship to a top art school. He did well, graduated, and moved to Chicago. His career has been up and down. Failing to get commissions, getting bad reviews of shows, and losing competitions have all triggered major depressions. In spite of this,

George has succeeded in making a living as a sculptor, not, to say the least, an easy thing to do. But he has never been the major figure he believes he deserves to be. I'm not in a position to evaluate his talent, but I have no reason to doubt that he is every bit as good as he says he is. That piece of George does not sound depressed, although it may be compensatory. He has a great deal of rage over not being in the snobbish and highly restricted circle of fashionable sculptors who get commission after commission.

This is an ongoing torment for him. Should I advise him to lower his expectations? A cognitive therapist would. But I am inhibited by not knowing how major a talent his is, and even if it is not, the belief may be sustaining, albeit disappointing.

George has had a series of long-term affairs but never married. He loses sexual interest after a while and intercourse becomes sporadic. In his words, "I spice things up with an occasional visit to a prostitute. I don't consider this cheating—there's no emotion involved." His girlfriend probably knows and looks the other way. He feels loved by her, a feeling he reciprocates, and their "arrangement" seems to work.

After we'd been working together for several years, George told me, with much shame, that he occasionally deliberately wet his sheet with his urine, rocked himself in it, and fell asleep, deeply content and at peace. At first we understood this as a regression to infancy or early childhood when his mother, not yet chronically depressed, would dry and comfort him. That was true. But then I had another thought that understood this strange behavior as a way of releasing bottled up feelings, particularly those of grief. I said to him, "You're weeping through your penis," an interpretation he immediately grasped. That opened up new possibilities for mourning, and soon George wept copious tears for his tragically lost brother. He has not wrapped himself in urine-wet sheets since.

What is the take-home message from George's chronic depression? Alcohol is the worst possible anti-depressant, in fact, it is a depressant; unresolved mourning majorly contributes to depression, and bottled up feelings do too. George is definitely doing better. Yet he remains, and probably will remain, vulnerable to serious depressive episodes triggered by loss, disappointed aspirations, and perceived failure to receive the recognition and respect he believes he deserves. George knows all this and as painful as his depressions are, he pretty much accepts having to live with this vulnerability.

Suggestions for Therapists and Families

Let me address a few words to therapists treating chronic depression. First, depression is contagious (this applies even more strongly to those who live with a chronically depressed person). If you treat much depression, you are in danger of getting depressed yourself. I'm not sure that you can altogether avoid this, but some things help. Get a few manic patients, or better yet, patients without mood disorders. But I think the essential trick is to not buy into your patients' despair without denying that despair. Not an easy trick. Neither an optimist nor a pessimist be. Rather, be as much a realist as you can. Access your own feelings of rage, helplessness, and hopelessness and try to use them therapeutically. Allow yourself to identify with the depressed patients—all too easy to do—without losing your own identity—that's not easy at all. Get some therapy for yourself. Working with a supervisor or being in a supervision group is another plus. Perhaps most importantly, get out of the office and do some crazy enjoyable things that have absolutely nothing to do with depression. Go to the opera. Go to a nude beach. Do whatever you need to do to not become the lifeguard who drowns.

How about family members? They're in a much worse situation than therapists who work a lot with depression. After all, the therapist can go

to his or her own therapist and/or go mountain climbing, attend a symphony, travel in Antarctica, and generally enjoy life when he or she isn't doing therapy. That's not so easily possible for family members who are living with a chronically and severely depressed person. As I said above, depression is contagious. It evokes feelings of helplessness and hopelessness. It also evokes much intense rage. Remember Ron Smith's family. They sounded cruel and indeed they were, but their response is also understandable. Ron, however much he could not help being in the situation he was in, was nevertheless infuriating. This kind of family dynamic needs some professional help. I would strongly recommend family therapy. As a family member dealing with a loved one's chronic misery, you might also consider therapy for yourself. But mostly I think it helps to understand that your loved one has a disease, and though the sufferer does have some freedom of action, in many ways that disease does restrict his or her options in ways that person cannot change. There is also enormous sadness involved here. Seeing someone you love suffer so persistently and lose so much of life's potential can be and usually is heartbreaking. So you have a whole basket of really painful feelings to deal with. Don't underestimate the depths of your own suffering elicited

by sharing life and loving a chronically depressed parent, child, sibling, or mate.

Accepting and Working Through

“All right already. Let therapists take care of themselves and the siblings can go hang. I have enough trouble of my own. Enough, Dr. Levin. So now I know I have a chronic disability. What the hell good does that do me?” Perhaps a lot. How does one adjust to a physical disability? I know the analogy isn’t perfect, for your core self is involved in a way it usually is not in a physical disability with an emotional disability such as chronic depression. Even worse, the very tools you need in order to adjust are compromised by your disease. Nevertheless, let’s borrow some thoughts from the adjustment to physical disability literature. What does it suggest?

First, think of yourself as more able than disabled. Think about what you *can* do, particularly in the area of the emotional, rather than what you can’t do. That doesn’t mean denying your disability. But it does mean recognizing and embracing your emotional strengths. Do you have the capacity to love, for example? Have you shown courage in dealing with this damned disease? Are you able to work? Are you able to make

contributions to others' welfare? Do you have moments of joy, however fleeting? Moments of wonder and awe? Moments of aesthetic bliss? Times when you are creative? I can go on, but it's better for you if you make your own list. And remember, your disease still is telling you that you are no damn good and good for nothing. Talk back to that voice; it is the counsel of despair.

A closely related, very helpful strategy is to avoid identifying with your disease. You are not your depression; you *have* depression, just as you would not be your arthritis if you had arthritis. So insofar as possible, separate your true self from your disease.

Try to get as much as possible out of life in spite of your depression. Grab on to your free, or relatively free, interludes and ride them for all they're worth. Even in your times in the pit, there are probably possibilities for pleasure out there, if not in this moment, perhaps in the next one. Try to be aware of the times when your thoughts aren't truly your own; rather, they're your disease speaking. When you identify that foreign voice talk back to it! Get as much distance from it as you can!

Be as open to and as nonjudgmental of your feelings as you can possibly be. Try to stay with the discomfort accompanying many of them.

Stay in psychotherapy. It may not cure, but it most certainly helps. Work with a psychiatrist who is not only a competent and creative psychopharmacologist but is also a human being who cares about you and isn't afraid to express that caring. Encourage your psychiatrist to keep up with the latest treatment advances and discuss their applicability to your situation with you. Painful as it can be, try to stay with the trauma work you are doing with your therapist.

All of the above helps, but the core of the rehabilitation approach is *mourning* your chronic depression itself. That, of course, doesn't preclude mourning other losses in your life, which is just as therapeutically vital. How does one mourn a disability that takes so much away and lies so close to your core self? There's no magic formula, but Kübler-Ross's well-known stages of grief come to mind. For all the apparent complexity, mourning your depression is quite simply grieving for it. Kübler-Ross describes a process starting with denial. The whole thrust of this book is to break down your denial. Nevertheless, it will come and go, sometimes mercifully protecting you, other times radically impeding your capacity to come to terms with your situation. Next comes anger. We've discussed rage at the depression itself. Let yourself feel it in all its intensity. Express it in any non-self-destructive way you can.

Then, if possible, and only when you're fully ready, try to let it go. Then comes bargaining. "Dear God, if You'll only lift my depression, I will stop beating my wife." An absurd example, perhaps, but you get the idea. Bargain in any way that feels right to you until you realize the futility of that bargaining. The realization is likely to drop you into the next and most painful step: depression. This is the depression over being depressed that we have discussed. Don't criticize yourself for being depressed about your depression; it is natural and inevitable. You don't want to stay there. Yet you need to experience that secondary depression. Kübler-Ross was wrong about the stages being sequential and the sequence being linear. The reality is that the stages occur in many different orders and that the normal pattern is to oscillate back and forth, let's say, between acceptance and bargaining or depression and anger. So in the course of mourning either past losses or your depression itself, you will pass through each of these stages many times and in many different orders. But all this is a necessary process, a part of the mourning work which will, at some point, come to an end.

At this point it is useful to remember that "sadness is a feeling; depression is as disease." Try to weep for the deprivations your depression has imposed on you. Stay sad as long as you need to. This is

not the sadness that is a symptom of depression; rather it is curative (however imperfectly). And finally, coming out of being depressed about depression, or better, feeling sad that you are depressed, you will have an opportunity to reach some sort of acceptance of your disability. Now you know what you have to live with and have some inkling of the positive possibilities underlying that “have to.” Using that knowledge to accept this ongoing reality of your life changes things. Hopefully, you will experience the Zen paradox that to accept is somehow to transmute. Acceptance is the key. I can’t tell you how or what form it will take. That is an individual thing, but I have seen it happen. Acceptance truly is a deal changer. It does not mean ceasing by every possible means to ameliorate your depression; rather it means accepting the present reality, even as you seek to change it.

The Dialectic of Acceptance and Hope

As I was looking for a way to finish this book, I happened to read Elie Wiesel’s *Open Heart*, an account, among other things, of his triple bypass operation. It is not a book about depression, but something Wiesel says in it seemed to me to be highly applicable to living with chronic depression. Wiesel tells us that after Auschwitz, which he survived, he thought that never again would wars, hatred, racism, or anti-Semitism be

possible. He found out that he was wrong. As he says, after Cambodia, Rwanda and Bosnia, he realized that man had learned nothing. That nearly led him to despair. But it didn't. That side of Wiesel is a hard-headed realist who accepts humanity with all its flaws and all its potential for radical evil. Yet, he goes on to tell us that each day he says with Maimonides, the twelfth-century sage who wrote this prayer, "Though He tarries, I believe in the coming of the Messiah." What Wiesel is saying is that somehow we must accomplish the daunting task of accepting the reality of pain without losing hope in a better future. For our purposes (whether we be Jews, for whom the Messiah has not come, or Christians, for whom He has), belief in the coming of the Messiah is not belief in a person or an event. Rather, it is a manifestation of hope. In the case of chronic depression, there can be hope that a sustained period of remission will occur, that the disease will burn itself out, or that a new and effective treatment or pharmacological cure will come into being.

This leads me to conclude that the best that can be done to come to terms with chronic depression is to participate in a dialectic between acceptance and hope, a dialectic that denies the reality of neither of its polarities, seeing them as complementary and intertwined. As difficult as it is, try to position yourself within, or better yet, take within yourself this

dialectic of acceptance and hope. It has the potential to make living with chronic depression at least tolerable, and in the best of cases, considerably better than tolerable.

About the Author

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