THE REHABILITATION APPROACH

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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 inpidual 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.