Coping With Depression

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Despite mental health professionals' massive efforts to educate the public about depression, misconceptions and lack of knowledge prevail. To obtain sound treatment and to make the best use of it, you must educate yourself. Given the complexity of the topic and the vastness of the literature, educating yourself is no easy matter—especially when you're depressed.

At The Menninger Clinic, we have put a great deal of energy and thought into educating patients and their family members about psychiatric disorders and their treatment. This manuscript is a précis of my book, *Coping with Depression*, published by **American Psychiatric Publishing, Inc**. Earlier versions of this material have been published in chapters on depression in my recent book, ***Coping with Trauma: Hope through Understanding***, 2nd Ed. (also published by American Psychiatric Publishing in 2005) and in my previous book, *Traumatic Relationships and Serious Mental Disorders* (published by John Wiley & Sons in 2001) as well as in my article, "Coping with the catch-22s of depression: A guide for educating patients" (published in the ***Bulletin of the Menninger Clinic***, Volume66, pages 103-144).

This material has been developed from psychoeducational programs I have conducted on trauma throughout The Menninger Clinic over the past decade, and it forms the basis for the current educational course on depression in the Professionals in Crisis program. Much of the credit for my understanding of depression goes to the patients who have participated in these educational programs; they are the true experts, and they have taught me graciously.

In teaching depressed patients about depression, I quickly learned that merely talking about all the things they needed to do to recover was futile; after explaining why these things don't work easily, they tuned me out. I realized that we need to start with the obstacles to recovery. I started using the concept of catch-22 (from Joseph Heller's book): *all the things you must do to recover from depression are made difficult by the symptoms of depression*. For example, you should eat well, sleep well, be active, and think realistically. Yet the typical symptoms of depression include poor appetite, insomnia, lethargy, and negative thinking. Above all, you should maintain hope, but depression can bring hopelessness. Paradoxically, acknowledging the seriousness of the illness and the difficulty in recovering provides a sound platform for hope.

On the basis of extensive work with hospitalized patients, I came to view depression as a consequence of stress pileup. I believe that most of us have the capacity to become depressed in the face of sufficient stress, although we have different levels of stress tolerance. The stress pileup concept fits a developmental view of depression, which I view as a response to the accumulation of stress over the lifetime. And we must consider stress pileup on multiple levels: biological, psychological, and social.

The sections to follow mirror the chapters in *Coping with Depression*, which is divided into five parts: Groundwork (Depression, A Rock and a Hard Place, Agency and Elbowroom), Development (Constitution, Attachment, Childhood Adversity), Precipitants (Stressful Events, Internal Stress), Illness (Brain and Body, Related Disorders), and Coping with Catch-22 (Health, Flexible Thinking, Supportive Relationships, Integrating Treatment, Hope). Keep in mind that the literature on depression goes far beyond what any individual could master; any single book, no matter how substantial, will be a short summary. Thus the manuscript you're now reading is a short summary of a short summary. My intent is to give you the lay of the land and to inspire you to read and learn more. I've included selected readings and the end of this manuscript to provide you with a window to the wider literature.

Part I: Groundwork

1. Depression

In his masterful autobiographical memoir, *Darkness Visible*, author William Styron characterized "depression" as "a true wimp of a word for such a major illness," a word that "has slithered innocuously through the language like a slug, leaving little trace of its intrinsic malevolence and preventing, by its very insipidity, a general awareness of the horrible intensity of the disease when out of control." Most of us know what it's like to *feel* depressed; being *ill* with depression is another matter altogether, and we must not generalize from one to the other.

We can begin defining by depression by distinguishing it from anxiety, although the two are thoroughly entangled with one another. We can understand anxiety as a high level of negative emotion, on a spectrum that ranges from being calm and relaxed at one end to feeling anxious, fearful, panicky, and terrified at the other. We need negative emotion as a motivating signal to steer us away from danger and adversity. Depression, on the other hand, can be understood as a low level of positive emotion. Decades ago, psychologist Paul Meehl aptly characterized depression as stemming from a lack of "cerebral joy juice," neatly anticipating our current neurobiological understanding. Thus we can envision depression at the low end of spectrum of positive emotionality, which gradually increases from interest to excitement to joy, elation, and euphoria. Mania represents an excess of positive emotionality. Just as negative emotions steer us away from harm, positive emotions, anchored in a neurobiological reward system, steer us toward what is good for us. Thus both anxiety and depression promote disengagement: anxiety promotes withdrawal, and depression robs us of the incentive to engage. Typically, the depressed person faces the dual challenge of increasing positive emotion and decreasing negative emotion.

There are several diagnostic categories of depression, depending on the severity and duration of the symptoms. Major depression is the prototype; this diagnosis requires at least two weeks of five or more symptoms from the following list: depressed mood, diminished interest or pleasure in activities, significant decrease or increase in weight or appetite, insomnia or hypersomnia, motor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicidal thinking or behavior. Dysthymic disorder entails less severe symptoms but a longer duration (at least two

years), and double depression includes major depressive episodes superimposed on dysthymia. Seasonal affective disorder is diagnosed when the onset and remission of depression occurs consistently at a particular time of year (most commonly taking the form of winter depression); diagnosing a seasonal pattern is important because of the potential helpfulness of light therapy.

2. Between a Rock and a Hard Place

Wrongly, we tend to think of depression as an acute illness from which you should recover quickly—especially now that we have antidepressant medication. Here's the rock: depression isn't that serious; if you'd just [do x], you'd snap out of it. The hard place: depression is a serious, persistent, mental-physical illness. It's tempting to stay on the rock, believing that you're not really that ill, but it's demoralizing and crazy-making: if you're not that ill, why are you having such a hard time recovering? You conclude that you're lazy or defective in some mysterious way, which is even more depressing. I think the hard place is better—facing the seriousness of the illness and having some compassion for yourself regarding how difficult it is to recover. Hope lies in a realistic view.

If you believe the popular stereotype, you might b e surprised about the sheer commonness and seriousness of depression. Statistics vary, but one major study found that 17% of the U.S. population suffers from an episode of major depression sometime in their lifetime, and women are twice as likely as men to experience depression. A World Health Organization study found the depression is currently the fourth most disabling disease worldwide, and it is anticipated to become the second most disabling disease by 2020 (only surpassed by heart disease). One reason for the level of disability is the sheer duration of depressive episodes. A major study of patients who required hospitalization for depression found that the median time to recovery was five months (i.e., 50% had recovered by 5 months). Moreover, we know that that there is a high likelihood of recurrence of depressive episodes, especially for persons who have experienced many such episodes or who continue to experience some residual symptoms of depression. But we must keep in mind that a major reason for these grim findings is that fact that the vast majority of persons with depression are not properly treated, and that proper treatment hastens recovery and decreases the likelihood of recurrence.

Plainly, depression is a major health problem worldwide. To summarize the problem: depressed persons may not realize that they're ill; if they do recognize it, they may not seek treatment; if they do seek treatment, they may not be diagnosed; if they are diagnosed, they may be under-treated; if they are adequately treated, they may not fully respond; and if they do respond, they may experience a recurrence. Keep this in mind: you are not a statistic. I think the bottom line is this: if you're depressed, you can do something about it. This brings us to the topic of agency.

3. *Agency and Elbowroom*

Richard Munich, MD, former chief of staff of The Menninger Clinic, proposed that a foundation of successful treatment is the patient's capacity to take agency for the illness. This is a tricky idea. Agency is the capacity to initiate action for a purpose. To recover from depression, you must take

action. Yet depression is an illness that constrains your capacity to take action. Nonetheless, despite some level of illness, you have some remaining agency, some elbowroom. For example, although you have low energy, you still have some energy, and you must use this energy as leverage to get more. In addition, you have some elbowroom in your ability to seek help from others.

Taking agency for the illness is most obvious in relation to recovery: you can learn that you can do something—many things, in fact—to become less depressed. Yet agency also can play a role in the development of the illness. I've stated that depression is a result of stress pileup. We can divide stress into two broad categories: fateful and self-generated. Fateful stress is unavoidable—accidents, job loss, deaths. But we also suffer from partly self-generated stress, for example, being perfectionistic, working too hard, or contributing to conflicts in our intimate relationships. Being mindful of self-generated stress is extremely important. If depression stems from stress pileup, minimizing stress and learning to cope with stress are crucial in recovering and staying well. We have no leverage over fateful stress, but we have some leverage over self-generated stress.

To repeat, the illness of depression constrains your agency, but it doesn't eliminate it entirely. Sociologist Talcott Parsons construed illness as a social role, and he articulated what I consider to be the single most important point about illness: being ill, *you cannot recover by a mere act of will*. You cannot change your mind and no longer be depressed; you're ill. Recovery takes many acts of will over a long period of time. Hence illness frees you from social and occupational obligations. Yet illness imposes other obligations: you must seek and cooperate with treatment in order to legitimate the freedom from usual responsibilities. This isn't so easy to do when you're depressed, but it's absolutely essential if you wish others to give you some slack.

Emphasizing agency for illness is essential but it poses a difficult problem. A free agent makes choices and thus bears responsibility. It's a slippery slope from responsibility to blame, condemnation, and punishment—all of which will only make matters worse. The challenge is to accept responsibility for the sake of empowerment, not self-blame. If you can understand how you got into depression—unwittingly contributing to piling up stress—you are in a stronger position to get out of it and stay out of it. Part of recovery will involve constructive self-criticism, and for that you'll need a compassionate understanding of the reasons for your depression and the seriousness of the illness. You walk a tightrope in taking agency for your illness, putting yourself at risk for one of two mistakes: taking responsibility for things you can't control, and failing to take responsibility for things you can control. The venerable serenity prayer captures the challenge: grant me the serenity to accept the things I cannot change, the courage to change things I can, and the wisdom to tell the difference. You'll need knowledge as well as wisdom, and this manuscript is intended to provide some glimpses of that knowledge.

Part II. Development

4. Constitution

With the help of biological psychiatry and neuroscience, we are learning a great deal about constitutional vulnerability to depression. I will mention some key findings, but you must keep this in mind: biology is not destiny. Biological factors might place you at higher risk for depression, but you are an agent; you can do something about your level of risk.

We know that depression runs in families, and this is due not only to environmental factors but also to genetic factors. Depression is multifaceted, and there is no single gene for depression; many genes contribute, and some are being identified. But we must avoid the fallacy of genetic determinism, the idea that certain genes inevitably and directly cause psychiatric disorders. Genetic makeup is not destiny. And genetic vulnerability takes the form of rendering you more susceptible to depression in the face of environmental stress. Thus, being genetically predisposed to depression, a lesser degree of stress pileup could precipitate an episode of illness.

We are also learning that prenatal stress can be an early source of stress vulnerability. Maternal stress has an impact on the developing fetus, such that heightened stress reactivity can be evident even in newborns. Again, biology is not destiny: these effects are relatively mild in degree, and many other developmental factors will determine whether there are lasting effects. I note these findings merely to draw your attention to the fact that depression can have a long developmental history and that it is fundamentally based in responsiveness to stress.

Temperament—biologically based personality characteristics—also can play a role in stress susceptibility. Best studied is anxious temperament, a form of distress proneness that is evident early in infancy. The hallmark of the temperamentally anxious child is shyness and cautiousness in novel situations, as evident in the preschooler who sits on the sidelines observing, rather than diving into play. Some clinicians also believe in depressive temperament, evident in the contrast between persons who are more prone to gloominess and pessimism versus those who are characteristically more buoyant and optimistic (i.e., at opposite ends of the spectrum of positive emotionality).

Gender also plays a significant role in vulnerability to depression; beginning at adolescence—but not before—females are twice as likely as males to suffer from depression. This sex difference is partly constitutional but substantially social. The role of hormonal differences in vulnerability to depression is a matter of active research and the findings are complex. Hormonal changes (e.g., postpartum, menopause) are likely interact with genetic vulnerability and environmental stress to contribute to depression. A multitude of psychological and social factors also contribute to sex differences: negative body image, exposure to trauma, social inequalities, and coping strategies conducive to depression, such as proneness to rumination. None of these factors is unique to women, but they are more prominent among women.
To reiterate: biology is not destiny. If you have children and are concerned about their vulnerability, you might keep this in mind. These biological factors affect *risk* for depression; being aware of heightened risk, you can be alert to early signs of illness as well as treatment options that

can help you intervene more promptly and effectively; prevention and early intervention is the best medicine.

5. Attachment

Freud wrote that "We are never so defenseless against suffering as when we love, never so helplessly unhappy as when we have lost our loved object or its love." John Bowlby developed attachment theory in the context of studying parent-infant separation and depression. Bowlby proposed that we all need secure attachment relationships throughout our lifetime. Secure attachment entails confidence that, when you're distressed or ill, your attachment figure will be available and emotionally responsive, which boils down to having your mind in mind. A secure attachment relationship provides a safe haven and a feeling of security as well as a secure base, a platform for exploration. A secure base enables us to explore not only the outer world but also the inner world, our own mind and the minds of others. I often remark that the mind can be a scary place; as a patient rightly responded, "Yes, and you wouldn't want to go in there alone!"

Insecure attachments are a significant developmental contributor to depression. In this context, psychologist Sidney Blatt identified two basic forms of depression: dependent and self-critical. These two types of depression relate to two broad themes: loss and failure. Individuals who suffer from dependent depression are highly sensitive to separation and loss, whereas those who suffer from self-critical depression tend to be perfectionistic, driven, and highly responsive to failure. Sadly, these two forms of depression are not mutually exclusive; themes of both loss and failure are commonly intertwined. As Freud appreciated, we can lose our love object (loss) or its love (failure).

I consider attachment theory to be a hopeful theory, because attachment is flexible throughout the lifetime, from infancy onwards. Infants can be securely attached with one caregiver and insecurely attached with another, depending on the nature of their interactions. Attachment is a biological need, like the need for food and water. Most persons don't give up on seeking attachments. And attachments are the cornerstone of healing. Many persons who are depressed feel profoundly alone and isolated—often in conjunction with shame about the stressful events in their life as well as their depression. When they can make contact with others who understand what they are going through and show compassion, they heal. Attachment is the basis of the power of therapy ranging from individual to group therapy, hospitalization, and support groups. Ultimately, establishing or rebuilding secure attachments in friendships, family relationships, and intimate relationships is the best route to recovery and the best protection against recurrence.

6. Childhood Adversity

As I've already indicated, stress pileup can begin early in life, exemplified, for example, by mother-infant depression. Postpartum depression affects from 10-15% of women and, at worst, can last a matter of months. Depending on the severity of maternal depression, the mother-infant relationship can be more or less affected. It's not the mother's depression per se but rather the mother-infant interaction that's crucial. Not uncommonly, depressed mothers are relatively inactive

and unresponsive to their infants, as well as showing negative emotions. Their infants show depressed behavior in turn (although the infant will not show depression with a non-depressed caregiver). Fortunately, given the commonness and potential seriousness of mother-infant depression, clinicians have developed a range of interventions that promote more positive interactions. Keep in mind that history is not destiny: many developmental factors come into play to determine the long-range impact of mother-infant depression. Yet the potential seriousness of the consequences underscores the importance of seeking treatment for postpartum depression (or maternal depression on any other basis).

I have already noted in conjunction with attachment theory that early childhood loss is a risk factor for depression in childhood as well as later in life. Yet Bowlby and others have emphasized that the impact of loss of a primary caregiver in childhood will depend greatly on attachments in the wake of the loss. If the child develops other secure attachments, subsequent depression is less likely. When the loss is followed by neglect or other forms of trauma, however, subsequent depression is more likely.

As Bowlby's work highlighted, childhood trauma is a prominent risk factor for depression in childhood and adulthood. Sadly, trauma takes many forms; childhood maltreatment is especially problematic. Childhood maltreatment includes not only physical, sexual, and psychological abuse but also physical and emotional neglect. All forms of maltreatment are risk factors for depression. In addition, childhood and adolescent depression are risk factors for adult depression, in part because they are stressful in themselves and in part because they are likely to create stress by hampering development.

Fortunately, development doesn't consist of merely piling up risk factors. As we develop vulnerability, we also develop resilience: the capacity to cope with challenge and adversity. We pile up stress and also garner resources for coping. Factors that promote children's effective functioning include ability to regulate emotional distress; high intelligence and academic competence; positive self-esteem and self-efficacy; easygoing temperament and ability to elicit positive regard and warmth form caregivers; and social competence. Primarily, however, resilience rests on good relationships—secure attachments in particular. Hence the flexibility of attachment over the lifetime is a major saving grace.

Part III. Precipitants

7. Stressful Events

A large majority of depressed persons experience a severe adverse life event—or many—prior to the onset of depression. Such life events include losses, such the death of a loved one, and failures, such as an unsuccessful business venture. Depression also can be brought on by chronic difficulties, such as severe marital conflicts or serious problems with children. Feeling let down by someone you count on can be a depressing stressor. Because of its extreme nature, traumatic stress is a common precipitant of depression. The subjective experience of stressful events— their

meaning—also plays a significant role in depression. When you feel humiliated or trapped, you're especially vulnerable to depression.

The majority of persons who suffer an episode of major depression have experienced one or more major stressors in the period prior to depression; yet only a minority of persons exposed to stress respond with major depression. Hence we must understand the nature of vulnerability to depression in the face of stress. Biological factors contribute to this vulnerability; these factors include not only genetic makeup but a history of prior stress, potentially beginning prenatally. Personality factors, such as feelings of inadequacy and low self-esteem also contribute to vulnerability. A history of childhood maltreatment is a significant risk factor for adult depression, because it contributes to biological and personality vulnerability as well as a greater likelihood of entering into subsequent stressful relationships. Thus we can view depressive episodes in adulthood as a culmination of a developmental cascade.

Not only do stressful life events and difficulties contribute to the onset of depression but also ongoing stress can prolong the duration of the episode and interfere with response to treatment. Stress also plays a significant role in recurrences of depression. Accordingly, to reiterate an earlier point, minimizing stress to the extent humanly possible and learning to cope with stress more effectively are essential in the process of recovering and remaining well. Taking agency for illness, you'll benefit from identifying anything you're doing that contributes to the stress you experience; examples include taking on too many responsibilities, abusing drugs or alcohol, neglecting your health, entering into unsupportive relationships, behaving in ways that contribute to conflict in relationships, and failing to seek support from others when you need it.

8. Internal Stress

In addition to experiencing stressful events in your life, you can create stress in your own mind; thus it's important to take account of the role of the internal world as well as the outer world. Of course, your internal world has the most pervasive influence. We can consider internal stress in the category of self-generated stress. Although I wouldn't want to convey that internal stress is easy to control, you can exert some influence over it; you have some leverage.

Perfectionism is a glaring example of internal stress and a notorious contributor to depression—especially evoking a feeling of failure. Perfectionism is not all bad; holding high standards often is essential and fulfilling. Yet perfectionism is conscientiousness taken to an extreme, often as a way of compensating for self-doubt and feelings of inadequacy. At worst, no matter how well you do, you can continue to raise the bar, making success impossible; that's depressing. Moreover, you not only can hold high standards for yourself but also can believe unrealistically that others hold the same unrealistic standards for you; and you also can hold others to unreasonable standards. Thus perfectionism can create stress in relationships— stress in the external world as well as the internal world. Perfectionism is not easily changed, and you may well need help from psychotherapy to do so.

Guilt feelings and shame are additional internal stressors that contribute to depression. Although guilt and shame overlap, guilt feelings stem from harm you believe you have done to others whereas shame reflects a pervasive feeling of defectiveness, a sense that your core self is bad. Shame plays a major role in self-critical depression, and perfectionism contributes powerfully to shame. Unfortunately, guilt and shame tend to promote withdrawal and isolation, which also contribute to depression. To overcome guilt and shame, you will need to go against the grain, talking about these feelings with someone you trust who can help you see yourself in a more objective and compassionate way.

Frustration and anger also play a significant role in depression. You might have heard that depression is anger turned inward, and there is a lot of truth in this idea. Many depressed persons have difficulty expressing anger outwardly but uninhibitedly criticize, berate, and attack themselves. I believe that resentment plays a particularly powerful role in depression. Resentment is a chronic stressor, an enduring source of strain. I think of resentment as stifled anger; both the resentment and the stifling generate wear and tear on the mind and body. Resentment also entails a one-down, subordinate position in relationships; it's associated with feeling trapped and oppressed, and oppression is depressing. To make matters worse, you might feel ashamed of your anger and resentment. I think of resentment as akin to being tied in an emotional knot; untying this knot requires resolving problems in attachment relationships. Although much resentment stems from past relationships, it's often fueled by similar conflicts in current relationships; both can be addressed in psychotherapy.

We know that low self-esteem plays a central role in depression, but I think the concept of "self-esteem" is too passive. A fan of agency, I prefer to think in terms of the way you relate to yourself: you might esteem yourself or devalue yourself. Thinking in this active way, you can exert some influence over your relationship with yourself: ideally, you can learn to develop a compassionate, benevolent, and empathic relationship with yourself—after the model of a secure attachment relationship with others. Developing more secure attachments with others—feeling known and accepted—is a main route to secure attachment with yourself, and vice versa.

Part IV. Illness

9. Brain and Body

With the advent of antidepressant medication, the public is becoming accustomed to thinking of depression as reflecting a "chemical imbalance." On the positive side, this concept has popularized the idea that depression is a real illness—it's physical. But I have some complaints about the chemical imbalance idea. It's misleading if you believe that there is a distinct kind of depression—a "chemical imbalance depression." On the contrary, the chemical imbalance stems from all the factors discussed in this manuscript. You might also think that a chemical imbalance can be influenced only by medication; on the contrary, your brain chemistry is influenced by psychotherapy and, more generally, how you live your life. In short, your brain chemistry is influenced by stress. Finally, believing that you have a chemical imbalance doesn't tell you much about the nature of your depression.

Earlier in this manuscript I noted the fact that depression is associated with considerable disability. When you're depressed you're ill: you're in a state of ill health. Much of this state relates to elevated stress hormones (including cortisol) that contribute to problems with energy, appetite, sleep, and sex drive.
In addition, depression is associated with changes in patterns of brain activity (which, in turn, are associated with the activity of neurotransmitters like serotonin, norepinephrine, and dopamine, some of the chemicals in the "chemical imbalance"). William Styron presciently likened depression to a howling tempest in the brain. We now know, thanks to neuroimaging studies, that depression is associated with heightened activity of the amygdala, a structure deep in the brain that instantly senses danger and orchestrates the fear response. This heightened amygdala activity, along with elevated stress hormones, attests to the fact that depression is a high-stress state. Darwin wisely stated that fear is the most depressing of the emotions, and we have seen that depression is intertwined with anxiety—a high level of negative emotionality.

Depression is also associated with impaired functioning of the prefrontal cortex, an area that has been called the brain's executive. Your prefrontal cortex is active when you concentrate and exert mental effort to hold a goal in mind, prioritize your actions, and solve complex problems. Your prefrontal cortex also automatically helps you keep a rein on the intensity of your emotional distress. As you know from experience, all this is difficult to do when you're depressed; your brain power is compromised. You're likely to need help from others to think objectively and solve problems: two prefrontal cortexes are better than one.

Fortunately, the neurobiological changes associated with depression are reversible; otherwise no one would recover. We now know that the brain is highly plastic; growth-promoting factors facilitate the healing of brain cells, and we even grow new brain cells. Antidepressant medication, various forms of psychotherapy, and managing the stress in your life can facilitate this healing process.

10. Related Disorders
Having a broken leg doesn't prevent you from getting the flu. So it is with psychiatric disorders; if you're suffering from depression, you're also likely to have other disorders. I've mentioned anxiety repeatedly. Here I will make note of other disorders commonly associated with depression: bipolar disorder, substance abuse, personality disorders, and general medical conditions. I will also include some comments about suicidal states.

Bipolar disorder is associated with alternating manic and depressive episodes, although depressed mood is generally more pervasive than manic periods. Manic episodes are associated with abnormally elevated mood, heightened activity, inflated self-esteem, and decreased need for sleep. Not just euphoric feelings but also frustration and irritability can be associated with mania, especially in the face of obstacles to goal-directed activity. Mania comes in degrees; less severe degrees are diagnosed as hypomania (and bipolar II disorder). Like depressive episodes, manic

episodes can be triggered by stress, most commonly by schedule disruption (especially not getting enough sleep). Manic episodes also can be triggered by success, which can rev up the reward system and lead to an escalating pattern of goal-directed activity. Confusingly, both manic and depressive symptoms can be intermingled in mixed episodes, alternating from day to day or hour to hour. Medication can facilitate recovery from manic episodes and is crucial to prevention; psychotherapy also can be helpful in prevention.

Substance abuse is often thoroughly intertwined with depression; I view it as a catalyst, because it can speed up your slide into depression. Intoxication and withdrawal can be a straight path to depression (and mania), as evidenced in substance-induced mood disorders. In addition, substance abuse contributes to stress in a multitude of ways: substance abuse can contribute to stressful life events such as job loss or arrests; it can contribute to internal stress, such as guilt feelings; and—most important—it plays a major role in relationship conflicts. Substance abuse not only plays a role in precipitating depression but also interferes with recovery. Both substance abuse and mood disorders tend to be recurrent, and the recurrence of either one raises the risk of recurrence of the other. Hence ongoing treatment for both disorders is essential.

Personality disorders revolve largely around persistent problems in close relationships. Many of these disorders involve exaggerations of normal personality traits; for example, you might be excessively dependent, avoidant, or compulsive. Borderline personality disorder is more complex, reflecting a pattern of emotional and interpersonal instability centered around attachment disturbance, namely, a fear of abandonment and aloneness frequently connected with childhood trauma. Personality functioning plays a major role in depression inasmuch as personality influences key relationships; personality problems are an important contributor to partly self-generated stress in relationships, and this domain of stress is most prominent in depression. Ironically, focusing on personality disturbance is a hopeful view: here you have some leverage over stress. Of course, personality change requires considerable effort over an extended period of time, and you're likely to need help in working on personality disturbance. Fortunately, psychotherapy can be an effective source of help.

Innumerable general medical conditions can contribute to depression, including endocrine disorders, infections, degenerative diseases, cardiovascular problems, and some forms of cancer. Thus I believe you should obtain a thorough medical evaluation to investigate such possible causes of depression, even if the depression seems to have been brought on by a major psychological stressor. Such conditions can make you more vulnerable to becoming depressed in the face of stress. Moreover, depression can complicate the course and treatment of a wide range of general medical conditions. In short, mental and physical health are thoroughly intertwined, both being linked to stress. One point cannot be overemphasized: your physical health plays a central role in improving your resilience to stress and depression.

Depression is the psychiatric condition most frequently associated with suicide, and the diagnostic criteria for depression include recurrent thoughts of death and suicide. Suicidal behavior should be

distinguished from deliberate self-harm (e.g., self-cutting or impulsive overdosing), which is intended to provide temporary relief from unbearable emotional states. Suicide typically reflects a feeling of hopelessness coupled with a wish for permanent escape from emotional pain through death. One of the most pernicious forms of distorted thinking in suicidal states is the idea that loved ones would be better off without you—a glaringly unrealistic belief given the traumatic impact of loss through suicide. Suicidal states often stem from a kind of "perfect storm" in which many factors come together: emotional pain, a feeling of humiliation or entrapment, anxiety or panic, and alcohol intoxication. But no one commits suicide without a method, and decreasing ready access to potential methods is a cornerstone of prevention. I know from having worked with chronically suicidal patients that suicide can seem like the only reasonable thing to do; from these same patients, I also know that even prolonged suicidal states can change, because years later they have been glad to be alive. In struggling with suicidal feelings, it's important to keep in mind that the vast majority of suicides are associated with active psychiatric disorders and that psychiatric disorders are treatable.

Part V. Coping with Catch-22

11. Health

In coping with depression, you might need to work on many fronts, contending with problems in sleeping, eating, activity, positive emotions, thinking, and relationships. Above all, you'll need to cultivate hope. You can't work on all fronts at once. If you're severely depressed, I think your first priority should be physical health.

Depression is a high stress state; thus, if you're depressed you need rest. Sleep is the most important source of rest, and insomnia plays a major role in precipitating and prolonging depression (although some depressed persons retreat by sleeping too much). Insomnia is a hard problem. Proper sleeping medication can be a great help, but it's generally best employed on a temporary basis, because it can become addicting and then compound your problems. Fortunately, given the seriousness and prevalence of sleep disturbance, clincians such as William Dement and Peter Hauri have provided expert guidance on sleep hygiene. Furthermore, because sleep disturbance is a symptom of depression (and anxiety), effective treatment for depression is likely to help.

Like sleeping and eating, activity is basic to physical health. Catch-22: you don't have the energy and motivation to be active. Yet, constrained as you might be by the illness, you're likely to have *some* energy. I think activity is one area where you have some leverage. You can't force yourself to sleep, and you can't force yourself to feel pleasure, but you can force yourself to be more active: sit up in bed, get out of bed, walk out of your bedroom, and on from there. Recovery entails small steps—the only way around catch-22. Eventually you can work your way up to exercise, which has been demonstrated to be a good antidepressant and a cornerstone of a healthy lifestyle that can become a foundation of wellness.

Depressed mood reflects the limited capacity for interest and pleasure, and positive emotion is an antidepressant. You can't force pleasure, but you can make an effort to engage in activities that might provide an opportunity for pleasure. Behavioral treatment for depression involves making a project of scheduling potentially pleasant, satisfying, and fulfilling events. You might also make a project of paying attention to positive experiences, being mindful of them rather than letting them slip by without notice. As you recover, your capacity for pleasure will increase; then you can make a point of enhancing positive experiences further.

If I'd started this manuscript by advising you that you need to recover from depression by sleeping and eating well, being active, and enjoying yourself, you'd have probably quit reading. Intuitively, you've been aware of catch-22 all along. True, you'll need to do these things—in small steps. But all this advice that's difficult to follow when you're in the depth of depression is easier to follow when you've recovered: then you're not in the throes of catch-22, and you can employ it to maximize your chances of remaining well. In addition, you can become alert to warning signs that you're slipping back into depression and then make an added effort to use these antidepressant strategies.

12. Flexible Thinking

Emotion and reason are thoroughly entangled in depression: negative thoughts evoke depression, and depressed mood evokes negative thoughts. A pertinent saying: when you're in a hole, the first thing to do is stop digging! Depression is typically a response to negative events, but the way you think about these events—and yourself—plays a significant role in the severity and course of depression. And you might not even be aware of your negative thoughts; they can flit through your mind automatically when anything goes wrong (e.g., "I can't do anything right!). These thoughts might be so common and reflexive that you hardly notice them, but they nevertheless fuel your depression. Noticing and questioning such thoughts is the key to cognitive therapy, one of the best researched treatments for depression.

Negative thinking of various sorts is notoriously common in depression; you're likely to think negatively about yourself, the world, and the future. At worst, negative thinking can fuel hopelessness, especially if you engage in *global* negative thinking: "I'm worthless, a complete failure!" "Things will never change!" "My whole life is ruined!" You're more likely to feel hopeful if you view your situation as temporary— "This will pass!"—and specific—"This project may be doomed, but I can do others." Such global negative thinking, and the hopelessness that goes with it, are unfortunate responses to childhood maltreatment, which can fuel feelings of helplessness and hopelessness. This learning may be a natural evolution of the child's experience: painful events did happen continually, the child was blamed for them, and the child was helpless to prevent them. Becoming aware that such thinking comes from the past and does not fit the present can help you be more objective and realistic. In sum, negative thinking is appropriate to negative events; over-generalizing is the problem.

Not only *what* you think but also *how* you think plays a role in depression. Ruminating about problems and failings—going over and over the same thoughts—is a good example of digging yourself deeper into the hole. Persons who ruminate have the illusion of gaining insight into their problems but, in reality, they're making themselves more depressed. Ruminating also wears out others who become tired of listening when you're merely spinning your wheels. Your challenge is to go from global ruminating (how much of a failure you are) to focusing on specific problems that you can solve. Becoming aware that you're ruminating is the first step; the next step is distracting yourself, and the last step is practical problem solving.

Psychiatrist Aaron Beck and his colleagues developed cognitive therapy to foster more productive thinking. Cognitive therapy doesn't promote the power of positive thinking but rather the power of *realistic* thinking. The four basic steps in cognitive therapy are (1) identifying automatic negative thoughts, (2) questioning their accuracy, (3) considering more reasonable alternatives, and (4) altering core negative beliefs (e.g., "No one will ever love me"). Skills learned in cognitive therapy can help you cope with stressful situations without sinking into depression. It's natural to feel bummed out when things go wrong. Cognitive therapy can help you interrupt the spiral from feeling bummed out to becoming ill with depression by blocking the thought processes that can put you deeper into the hole. In my view, cognitive therapy is a fine way to improve your relationship with yourself; instead of criticizing, discouraging, berating, and tormenting yourself, you can empathize with yourself, encouraging, reassuring, and supporting yourself. Catch-22: not easy when you're depressed, or even when you're not. Cognitive therapy is a lot of work and something you must incorporate into your daily life to obtain lasting benefit.

13. Supportive Relationships

Catch-22: when you're depressed, you most need support from others, but depression is likely to undermine potentially supportive relationships. When you're depressed, you're likely to withdraw, and when you engage, you're likely to be relatively unanimated and unresponsive, such that others do not find it rewarding to interact with you. Furthermore, depressed persons commonly seek reassurance but reject it; then they encounter rejection in return. Thus depression tends to be contagious, and perceptions of rejection are not entirely unwarranted, although depressed persons tend to overestimate the extent of the negative reactions they evoke. When you're depressed, it's important to remain mindful of the fact that, although your depression is distressing to others, those who care about you are strongly motivated by compassion and a wish to help. When you withdraw, they feel helpless, frustrated, and rejected.

Some ways of coping with these interpersonal problems include being aware of your behavior and its impact on others; acknowledging and discussing relationship problems related to your depression; widening your sources of support such that your intimate relationships are not unduly burdened; interacting with persons who have a relatively high tolerance for depression; and engaging in low-key activities such as going to a movie that do not require a lot of animation, energy, and conversation.

Another version of catch-22: the single most important buffer against depression is an intimate, confiding relationship; yet the single most potent perpetuator of depression is a stable bad relationship—one in which conflict and a sense of alienation prevails. There are no prescriptions for the dilemma of whether to stay or leave; couples therapy can be a significant help, but it requires the willing collaboration of both partners.

Like cognitive therapy, interpersonal psychotherapy is a well researched and effective treatment for depression. Interpersonal psychotherapy focuses on one or two of four interpersonal problem areas: unresolved grief, role disputes (e.g., different expectations about who should do what in a marriage), role transitions (e.g., leaving home, marrying, having children, divorce), and difficulty developing and maintaining relationships. Although it is less well researched, psychodynamic psychotherapy also has been shown to be effective in the treatment of depression; psychodynamic psychotherapy focuses on conflicts and personality problems that not only cause internal stress but also undermine secure attachments.

A significant part of coping with relationship problems stemming from depression is being aware of the tightrope that those who support you must walk. Ideally, those who provide support would offer steadfast encouragement. But they're not likely to be saints. Inevitably, they will fall off the tightrope in one of two ways: first, when their encouragement fails to relieve your depression, they might become more frustrated and critical, which exacerbates your depression; second, when that fails, they are likely to feel helpless and give up, which further exacerbates your depression. You can help those who support you to feel less helpless by coaching them, letting them know that they don't need to do anything to fix you; listening and thereby assuring you that you're not alone might be the most helpful thing that they can do. You can also let them know that you have other sources of support, so they will not feel so burdened. And you can seek couples therapy, marital therapy, or family therapy which will provide help to both of you.

14. Integrating Treatment

As the previous sections indicate, when you're recovering from depression, you'll work on many fronts, endeavoring to sleep well, eat properly, stay active, cultivate pleasurable experience, think flexibly, and maintain supportive relationships. Clinicians have developed specific therapies to help you on all these fronts: behavior therapy, cognitive therapy, interpersonal psychotherapy, psychodynamic psychotherapy, as well as marital and family therapy. Antidepressant medication also can help you on all these fronts: anything that decreases your anxiety and improves your mood will do so. But you cannot work on all fronts at once, nor can you participate in several forms of therapy. I've covered all these domains of problems and the therapies that go with them to help you prioritize. No one form of treatment is generally more effective than any other; you need to find a type of therapy and a therapist who will address the problems that trouble you most. You should also be aware that the "brand names" of therapies are misleading; in practice, many therapists are eclectic, drawing techniques from various effective therapies. In any event, you'll need a therapist who is flexible.

More important than the type of therapy is a solid therapeutic alliance, which involves a feeling of acceptance, a sense that your therapist trying to help, and an understanding that you are working actively toward shared goals. You should be aware that the most important determinant of the effectiveness of therapy is *you:* you'll benefit to the extent that you can be open and honest and collaborate with your therapist. By *collaboration*, I mean actively using the therapy as a resource for constructive change. Being in therapy is like going to college: what you get out of it will depend on the work you put into it. But, like college, you're faced with many choices.

One of the basic choices you'll make in seeking treatment for depression is deciding between some form of therapy or medication—or both. You'll need to make this decision in consultation with professionals; you cannot decide on the basis of reading. The current trend is away from psychotherapy and toward medication. Although the research findings defy simple summary, extensive evidence indicates that medication and psychotherapy can be equally effective when groups of patients are compared, although one or the other may be more effective for you as an individual. Also, there is some solid evidence that combining medication and psychotherapy is best for relatively severe depression. Psychotherapy can enhance the benefits of medication and vice versa. I believe that, short of overloading yourself, you should make use of everything that helps.

If you're so depressed that you're unable to function or if you are in a suicidal state, you should consider hospitalization. When he became depressed, William Styron sought outpatient treatment, took medication, went to psychotherapy, yet didn't improve. As he reflected on this experience, he wrote: "Why wasn't I in the hospital?" His psychiatrist didn't want him to be stigmatized, and he was only admitted after he became acutely suicidal. To recover, he needed several weeks of hospital treatment.

You might need several weeks or even months of treatment to help you recover from an episode. And you should know that we do not have a cure for depression: an episode of treatment will not prevent you from a recurrence. Maintenance medication is commonly employed to prevent recurrence, and maintenance psychotherapy can be employed in the same way. But I believe you must think beyond treatment: what matters most is how you live your life. You're most likely to remain well if you learn something from treatment that leads to durable change in your lifestyle, pattern of thinking, and relationships. Here's an analogy: you use exercise to lose weight; when you've lost the weight, you quit exercising. What happens then? Many depressed patients quit taking their medication when they feel better; this is a notorious precipitant of relapse.

In his masterful book, *The Noonday Demon*, writer Andrew Solomon offered succinct advice for relapse prevention: "act fast; have a good doctor prepared to hear from you; know your own patterns really clearly; regulate sleep and eating no matter how odious the task may be; lift stresses at once; exercise; mobilize love."

15. Hope

Hope is the foundation of recovery from depression. Aristotle rightly said that we're more likely to achieve our aim if we have a target. Thinking clearly about hope might help you cultivate it.

We can sharpen the concept of hope by distinguishing it from wishful thinking and optimism. All three involve positive expectations about the future, but hope applies to tragedy and serious suffering. You only need hope when you also struggle with fear and doubt. Wishful thinking is easy; hope is sufficiently difficult to count as a virtue. Optimism is too lighthearted a concept for circumstances that call for hope.

Hope requires a combination of agency (oomph or motive force) and pathways (a sense of direction—what your next steps might be). Hope also requires imagination, the ability to imagine alternative futures. When asked what gave her hope, one patient put it beautifully: "I can be surprised."

Sadly, depression undermines all you need for hope: it erodes your agency, makes it difficult for you to find pathways through problem solving, and undercuts your capacity to imagine. When you feel hopeless, you're likely to need the support of others who can encourage you and help you see solutions that might not occur to you. You might need to rely on *borrowed hope*—hope that others who are not seeing the world through the lens of depression are able to hold out for you.

I believe that our increasing knowledge about depression provides some basis for hope. Monumental effort, intelligence, and creativity is going into understanding the development of depression from the womb to senescence as well as into creating and researching treatments. It's realistic to hope for more effective treatments, and it's essential to stay informed about new developments as you care for yourself. Don't give up; imagine the unimaginable.

My mentor, psychologist Paul Pruyser, provided what I find to be the most compelling perspective on hope: "hoping is based on a belief that there is some benevolent disposition toward oneself somewhere in the universe, conveyed by a caring person." This wonderfully open-ended view is grounded in attachment, and it is consistent with psychoanalyst Erik Erikson's belief that hope is the virtue associated with the first stage of development, basic trust. I would add that the benevolent disposition toward yourself also can come from inside, in a secure attachment relationship with yourself.

I've offered some general thoughts about hope, but I've learned that hope is an individual matter. Hope comes and goes. What gives you hope might change from one time to another. Hope is likely to be intermingled with fear and doubt. You might be afraid to hope for fear of being disillusioned; thus hoping takes courage. Perhaps there's no firmer ground for hope than the possibility that some good ultimately might come from your painful experience. Writing about his own depression, Andrew Solomon concluded, "I have found that there are things to be made of this lot I have in life, that there are values to be found in it, at least when one is not in its most acute grip."

For Further Reading

General Literature

Allen, J. G. (2006). *Coping with depression*. Washington, DC: American Psychiatric Publishing.

Allen, J. G. (2005). *Coping with trauma: Hope through understanding* (2nd Ed.). Washington, DC: American Psychiatric Publishing.

Allen, J. G. (2003). Substance abuse is a catalyst for depression. *Menninger Perspective, 33*(1), 17-20.

Allen, J. G. (2005). *Coping with trauma: Hope through understanding* (Second Edition). Washington, DC: American Psychiatric Publishing.

Antony, M. M., & Swinson, R. P. (1998). *When perfect isn't good enough: Strategies for coping with perfectionism*. Oakland, CA: New Harbinger.

Aristotle. (1976). *Ethics* (J. A. K. Thompson, Trans.). London: Penguin.

Bifulco, A., & Moran, P. (1998). *Wednesday's Child: Research into women's experience of neglect and abuse in childhood, and adult depression*. London: Routledge.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Burns, D. D. (1980). *Feeling good*. New York: Avon.

Cronkite, K. (1994). *On the edge of darkness: America's most celebrated actors, journalists and politicians chronicle their most arduous journey*. New York: Dell.

Darwin, C. (1872/1965). *The expression of emotion in man and animals*. Chicago: University of Chicago Press.

Dement, W. C. (1999). *The promise of sleep*. New York: Random House.

Groopman, J. (2004). *The anatomy of hope: How people prevail in the face of illness*. New York: Random House.

Hammen, C. (1997). *Depression*. East Sussex, UK: Psychology Press.

Jamison, K. R. (1995). *An unquiet mind*. New York: Random House.

Jamison, K. R. (1999). *Night falls fast: Understanding suicide*. New York: Random House.

Lewinsohn, P. M., Munoz, R. F., Youngren, M. A., & Zeiss, A. (1986). *Control your depression*. New York: Simon & Schuster.

Lewis, L., Kelly, K. A., & Allen, J. G. (2004). *Restoring hope and trust: An illustrated guide to mastering trauma*. Baltimore, MD: Sidran Press.

McEwen, B. (2002). *The end of stress as we know it*. Washington, DC: Joseph Henry Press.

Martin, P. (1999). *The Zen path through depression*. New York: HarperCollins.

Solomon, A. (2001). *The noonday demon: An atlas of depression*. New York: Simon & Schuster.

Styron, W. (1990). *Darkness visible*. New York: Random House.

Whybrow, P. (1997). *A mood apart: Depression, mania, and other afflictions of the self*. New York: BasicBooks.

Williams, M. (1997). *Cry of pain: Understanding suicide and self-harm*. London: Penguin Books.

Yudofsky, S. C. (2005). *Fatal flaws: Navigating destructive relationships with people with disorders of personality and character*. Washington, DC: American Psychiatric Publishing.

Professional Literature

Allen, J. G. (2001). *Traumatic relationships and serious mental disorders*. Chichester, UK: Wiley.

Allen, J. G., Newsom, G. E., Gabbard, G. O., & Coyne, L. (1984). Scales to assess the therapeutic alliance form a psychoanalytic perspective. *Bulletin of the Menninger Clinic, 48*, 383-400.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidelines for the systematic treatment of the depressed patient*. New York: Oxford University Press.

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical, and research perspectives*. Washington, DC: American Psychological Association.

Bowlby, J. (1980). *Attachment and loss, Volume III: Loss, sadness and depression*. New York: Basic Books.

Brown, G. W., & Harris, T. O. (1978). *Social origins of depression: A study of psychiatric disorder in women*. New York: Free Press.

Busch, F. N., Rudden, M., & Shapiro, T. (2004). *Psychodynamic treatment of depression*. Washington, DC: American Psychiatric Publishing.

Flett, G. L., & Hewitt, P. L. (Eds.). (2002). *Perfectionism: Theory, research, and treatment*. Washington, DC: American Psychological Association.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.

Freud, S. (1929/1961). *Civilization and its discontents* (J. Strachey, Trans.). New York: Norton.

Gabbard, G. O. (Ed.). (2001). *Treatments of psychiatric disorders* (Third edition.). Washington, DC: American Psychiatric Publishing.

Gilbert, P. (1992). *Depression: The evolution of powerlessness*. New York: Guilford.

Goodman, S. H., & Gotlib, I. H. (Eds.). (2002). *Children of depressed parents: Mechanisms of risk and implications for treatment*. Washington, D.C.: American Psychological Association.

Gotlib, I. H., & Hammen, C. (Eds.). (2002). *Handbook of depression*. New York: Guilford.

Hirschfeld, R. M., Keller, M. B., Panico, S., et al. (1997). The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. *Journal of the American Medical Association, 277*, 333-340.

Kagan, J. (2003). Behavioral inhibition as a temperamental category. In R. J. Davidson & K. R. Scherer & H. H. Goldsmith (Eds.), *Handbook of affective sciences* (pp. 320-331). New York: Oxford University Press.

Kandel, E. R. (2005). *Psychiatry, psychoanalysis, and the new biology of mind*. Washington, DC: American Psychiatric Publishing.

McCullough, J. P. (2000). *Treatment for chronic depression: Cognitive Behavioral Analysis System of Psychotherapy*. New York: Guilford.

Meehl, P. E. (1975). Hedonic capacity: Some conjectures. *Bulletin of the Menninger Clinic, 39*, 295-307.

Menninger, K. A. (1987). Hope. *Bulletin of the Menninger Clinic, 51*, 447-462.

Munich, R. L. (2003). Efforts to preserve the mind in contemporary hospital treatment. *Bulletin of the Menninger Clinic, 76*, 167-186.

Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press.

Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry, 21*, 452-460.

Pruyser, P. W. (1987). Maintaining hope in adversity. *Bulletin of the Menninger Clinic, 51*, 463-474.

Roth, A., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research (Second edition)*. New York: Guilford.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford.

Snyder, C. R., Cheavens, J., & Michael, S. T. (1999). Hoping. In C. R. Snyder (Ed.), *Coping: The psychology of what works* (pp. 205-231). New York: Oxford University Press.

Watson, D. (2000). *Mood and temperament*. New York: Guilford.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.

Wells, K. B., Sturm, R., Sherbourne, C. D., & Meredith, L. S. (1996). *Caring for depression*. Cambridge, MA: Harvard University Press.

https://www.menningerclinic.com/clinicians/clinical-resources/coping-with-depression