Active Treatment of Depression

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Despite advances in medication and psychotherapeutic methods, most patients with depression are subject to frequent recurrences and lead damaged lives even when they do not meet criteria for an episode. This article suggests an active, directive, educational treatment approach for patients with depression, centered on two tools: 1. a Mood Journal, focusing on reestablishing the connection between the patients' mood changes and their external life; and 2. a series of "aphorisms" of depression, meant to be shared with patients early in treatment. These are assertions about the nature of depression and recovery from it, which help patients move toward taking an active role in questioning how the condition affects them.

INTRODUCTION

This article offers some guidelines for treatment of depression that are practical and helpful to therapists trying to help patients who do not respond quickly or easily to the standard prescribed treatments. Unfortunately, research is confirming that these are the majority of people suffering from depression, and that much care for the condition is superficial, inadequate, and based on false information. Many assumptions commonly held in the professional community—that newer antidepressants are reliably safe and effective, that short-term cognitive and interpersonal psychotherapies help most patients, that many people with depression can be effectively treated in primary care, that most patients can recover from an episode of depression without lasting damage—on close examination turn out not to be true at all (1-18). Indeed, even the DSM-IV distinction between major depression and dysthymic disorder seems less meaningful as research continues (5, 10, 13). Practice based on these assumptions is not only inadequate for treatment of depression, it can actually exacerbate the disease. Any experienced therapist has encountered patients who have been damaged by previous treatment, sometimes by highly qualified practitioners. Analytic therapy has reinforced depression in some who become mired in rumination. Directive treatment has demoralized and shamed patients by sadistically attacking their defenses. Short-term treat-

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ment at the behest of managed care can make patients feel like failures if they don't recover on schedule. Medication, even when effective, can reinforce passivity. ECT can do the same. Depressed patients who discontinue treatment are likely to blame themselves for the failure, adding evidence to their belief that there is no hope for them.

Most therapists and psychopharmacologists can help an individual patient recover from a single episode of depression, but our relapse rate is far too high: Patients who have one episode of major depression are 50 percent likely to have another; patients who have three episodes are 90 percent likely to have more (16). And, if we are honest with ourselves, we will also admit that our success rate is inadequate; for every patient we can help, we probably see two whom we can't.

We need to accept the idea that depression is a chronic disease, and help our patients plan their lives accordingly. Medications are usually helpful and often will be a part of patients' lives for some time to come, but rarely can they prevent future episodes and help patients resolve the problems that led to trouble in the first place. Patients must learn, practice, and plan to reinforce more adaptive ways of functioning—they must change how they deal with emotions, identify and challenge depressed thinking habits, change how they work, play, take care of themselves, cope with stress and loss, and interact with others. And therapists must be ready to give hope, to reduce shame, to be mentor, coach, cheerleader, idealized object, playmate, nurturer, *nudge*—many different roles. In doing so, inevitably, we must challenge many of our assumptions about the use of the self in psychotherapy.

MOOD JOURNAL

A hallmark of depression is the split between patients' experience of everyday life and their mood state. Episodes of depression, and relief from those episodes, seem to come "out of the blue," unconnected to everyday experience.

Vignette 1

Rachel came back to our self-help group, reporting that she had had a bad time. She had been overcome with the impulse to cut herself—an impulse she had had under control for some months. "But this time, I don't know what it was, just out of the blue, I was in the kitchen and I saw the knife, and I got the idea in my head, and nothing would do till I cut myself. And then I felt better. But now I feel ashamed and depressed again, like I'll never get well."

The group spent half an hour with Rachel, trying to help her figure out

what had triggered this impulse. It was fruitless. To every inquiry, Rachel just repeated her litany: "I don't know what it was about. It was just an impulse, out of the blue." Finally the group gave up and moved on to other things.

At the end of the meeting, as we were putting the chairs away, someone asked Rachel if she had had a good visit with her grandchildren over the holidays. "Oh, no," said Rachel, "that was a big disappointment. My son-in-law picked a fight with me, and they stayed away." It was as if you could see a series of little light bulbs going off over the heads of all the other group members. We all knew how important the grandchildren were to Rachel, and how much she had been looking forward to this visit. We knew the history of her conflict with her son-in-law, who used Rachel's one suicide attempt and hospitalization as evidence that she was somehow a menace to her grandchildren. It was plain as day to us—though not to Rachel—that there was a connection between her disappointment, anger, and shame at the canceled visit and her impulse to cut herself.

According to Tomkins's (19, 20) theory of affects and emotions, affects are hard-wired innate responses to stimulation. Tomkins lists eight primary affects: surprise, interest/excitement, enjoyment/joy, distress/anguish, contempt/disgust, anger/rage, fear/terror, and shame/humiliation. Affects have the function of amplifying or calling attention to the situations that engender them. They make good things better and bad things worse. When an affect is stimulated, it makes things happen all over the body. Infants are taken over by affects. Adults learn to control the outward manifestations of affect, but the same things are happening inside; we can become full of adrenaline, ready to fight or flee, or shamed and ready to retreat. Damasio (21) points out that affects are a manifestation of drives and instincts: "In general, drives and instincts operate either by generating a particular behavior directly or by inducing physiological states that lead individuals to behave in a particular way" (p. 115). Affects also have a social function; when we have the facial expression of sadness, we elicit sympathy from those around us; when we swell up with anger, we can scare people.

In the language of emotions developed by Basch (22) and Nathanson (23), an *affect* is the innate biological response to a stimulus, a *feeling* is our conscious perception of an affect, and an *emotion* is our individual learned response to an affect, including all the memories and associations that go with it. Affects are much the same in all of us; anger has the same internal

manifestations in one person as another. But emotions are unique: How I experience anger depends on all my previous experiences of anger. Emotions also are self-reinforcing; they engender memories and thoughts that perpetuate the affect. "An affect lasts but a few seconds, a feeling long enough for us to make the flash of recognition, and an emotion as long as we keep finding memories that continue to trigger that affect" (23, p. 51). A *mood* is a persistent state of emotion, one that we cannot shake easily by changing our thoughts or our environment. "Moods have their own halo effect: They recruit memory and any ongoing experience and color these with the prevailing mood state" (24, p. 19). Moods have a pervasive impact on the way we see the world and ourselves.

In other words, feelings are unavoidable phenomena, things that have a life of their own, that happen to us whether we want them to or not. But depressed patients have learned to fear their own emotions and believe it is better not to feel. Depression has been seen by some (22, 25-28) as an adaptive state, a regrouping of the self when we have done everything we know how to do and it has not solved the problem—a system-wide brownout of emotional intensity. Others, like Miller (29), see depression as an effort to deny one's own feelings, an effort that requires a continual supply of psychic energy. Both formulations tie patients' flattened affect and diminished responsiveness to the lethargy, lack of agency, and hopelessness of depression. The Freudian conception of depression as a state of incomplete mourning for a lost, ambivalently loved other suggests a decathexis from the rest of the world (30, 31). Self psychology's concept of the "depleted self" portrays the same passivity and withdrawal from a different perspective (32, 33). Stress-diathesis models of depression (31, 34–41) point to the unintended negative social consequences of patients' flattened affect and emotional withdrawal, which in a circular fashion maintain the depression. Regardless of the theoretical explanation, however, recovery from depression implies recapturing the ability to experience emotions, an ability that will enliven patients' apathetic, anhedonic state.

By definition, depressed patients are stuck in a depressed mood, a state where the only emotions likely to be experienced are negative ones. Naturally, patients try to control their experience of these emotions, but this does not lift the depressed mood. Paradoxically, they need to exert less control, to allow themselves to feel a full range of emotions in their moment-to-moment fluctuation as life happens.

A place to start is to help patients differentiate between mood and emotion. Much of the focus of treatment can be on helping them realize

that mood changes don't come "out of the blue" but are connected to external reality. One of the greatest "skills" of depression is the ability not to see those connections (42). The Mood Journal (*see* p. 512) is one tool for helping to regain that lost ability. Patients are asked to keep track of times when they experience a mood change (which does not have to be in a negative direction; it is very useful to find out what makes patients feel good), and to note the external, as well as the internal, circumstances (thoughts, dreams, associations), at the time. Review of this material in session usually demonstrates that patients' changes in mood had precipitants. Something happened that would have made a nondepressed person feel an emotion—usually anger, frustration, or rejection but sometimes joy, pride, or excitement—but the depressed person, instead of experiencing the emotion, experiences a global mood change, apparently unconnected to any precipitant.[1]

This need not be onerous homework. Two or three examples are all that can be successfully reviewed in a session. Some patients quickly catch on, however, and continue to benefit from using the Mood Journal on their own.

There are several important lessons that come from the Mood Journal. One is that patients' reactions to events are seen by the therapist as legitimate and understandable given the circumstances. This helps patients become more tolerant of themselves and begin to feel that they are not necessarily loathsome for feeling angry when someone hurts them. A secontl lesson is that moods change. In the midst of feeling absolutely horrible, patients' subjective belief is that they will always feel this way. But, except for the severely depressed, most patients do have fluctuations in mood, times when they feel better than their worst.

Another message is more subtle: By demonstrating that there are reasons why patients' moods go up and down, we are showing them that they are not crazy. The fear of loss of emotional control is one of the greatest secret worries of depression (43–47). Patients experience their mood changes as forces that overwhelm them, apparently for no reason whatsoever, and they fear that they are losing their minds. When we show patients that there are *reasons* for their mood changes, we give them hope.

[1]The Mood Journal borrows from Beck et al.'s Daily Record of Dysfunctional Thoughts (43) in asking the patient to keep careful track of the interaction of mood changes and internal and external events. However, in the Mood Journal, mood changes in a positive direction are also of interest, and the focus on cognition is absent. It is assumed that some of the benefit of the Daily Record of Dysfunctional Thoughts comes from the experience of mastery and detachment rather than the actual correction of negative thought patterns. Use of the Mood Journal in practice more closely resembles the tracking of pleasant and unpleasant events advocated by Lewinsohn et al. (44).

That the extent of the mood change may be vastly out of proportion to the event that causes it is a secondary problem. If mood changes have to do with events, there are things we can do with events; we can avoid some, control others, and learn to accept what we have no other choice about. Patients can begin to adopt a wait-and-see attitude toward mood changes, a little detachment.

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Date, time	Mood change	Externals (who, what, where, other unusual circumstances)	Internals (thoughts, fantasies, memories)

Instructions: When you detect a shift in mood, write down the change (e.g., from neutral to sad), the external circumstances (what you were doing, where, with whom), and the internal circumstances (what you were thinking about, daydreaming, or remembering).

Some patients will report not feeling anything. Something important happens in their lives, and they are not aware of feeling any particular way about it. Or they come to treatment and don't know what to say. This can be frustrating for the therapist, but hammering away at times like these can be terribly destructive for patients. Wachtel (48) proposes two strategies. One is to suggest that patients may be feeling something, just not what they think they are supposed to feel. Patients who have suffered a loss, for instance, may report just feeling numb, believing they ought to be feeling overwhelming grief. But sometimes with a loss we do not feel sad, we may feel relieved or angry or hurt. Suggesting that feelings other than the conventional expectation are possible may open a door to fruitful exploration. Wachtel's other suggestion is to point out to patients that they *are* feeling something—that feeling numb, bored, or indifferent is not feeling

[2]From Richard O'Connor, *Undoing Depression*, © Little, Brown, & Co. 1997. Used with permission.

nothing. *In fact, you seem to be feeling a great deal of indifference. What's that about?* Both these approaches get around the accusatory power struggle of trying to convince patients that they must be feeling something, which often ends up with them feeling angry at the therapist or more inadequate about themselves.

Another technique described by Wachtel and used, sometimes unwittingly, by many different therapists, is what he calls "strategic attribution." This is the process of telling patients that they are feeling something before they are fully aware of it themselves. *Your anger at your husband is beginning to get to you. It sounds like you're getting ready to make a decision about your job.* Put forth baldly here on the page, comments like these can sound disingenuous, but I do think this is common practice, and it behooves us to be fully conscious of our methods. Sometimes therapists who view themselves as merely empathic are actually actively prompting patients on how to feel. Whatever the rationale, when we do this right—when we are indeed not too far ahead of the patient, when we are speaking of something that is preconscious or even conscious sometimes, just not right now—it can be a way of giving permission to feel, of conveying the idea that a warded-off emotion is natural and acceptable under the circumstances. Such comments—which if accurate really are deep empathy—can be an important step toward beginning identification with, or internalization of, the therapist as a more benign, less dangerous object.

APHORISMS OF DEPRESSION

Depressed patients benefit from structure and a time frame. *This is how therapy works: we talk about feelings; you need to report to me changes in your feelings, moods, behavior; you need to be honest with me about self-destructive behavior, etc. . . . This is what you can expect from medication. . . . These are circumstances when you should call me. . . . This is how long treatment might take. . . . This is how we will deal with your insurance company. . . . As you're improving, we'll talk about how to integrate change so that you can do without treatment.*

The therapist's knowledge about depression and its effects can help overwhelmed, confused, and despairing patients bring clarity and hope to their present condition. The mere act of asking intelligent questions that reveal a familiarity with the disease and suggest connections between seemingly random phenomena is in itself an educational process that can be quite helpful. Patients learn "that there is something 'normative' about [their] behavior even if it isn't 'normal' for him or her" (49, p. 84). As patients begin to appreciate that there is a body of knowledge about their

condition that can be helpful to them, they can become students of their own disease.

Patients do not recognize that much of what keeps them depressed is behavioral, cognitive, and relational patterns that they have learned in adaptation to the disease; instead, in their depressed state, these patterns seem part of themselves. Likewise, they do not recognize that they can learn new, more adaptive skills. These will seem awkward at first, like anything new, but eventually they can become integrated into the self. We no longer have the luxury of the years-long "middle phase" of treatment where the nondirective therapist could count on patients to learn new behavior through trial and error. We owe it to our patients to provide direction and to give them a cognitive map of how they will be expected to recover. One of the best ways we can help them is by reminding them to go to the psychic gym: that they are developing new muscles, new coordination, and the way to do that is through practice.

To help my patients understand how they can best help themselves, I often provide them with a list of aphorisms about depression, which can serve as a stimulus for thought and discussion. I find that the following flat assertions (Table I), presented as statements of fact, have a way of getting around defensiveness. Patients learn that these observations are manifestations of their condition, not weakness or lack of character on their part. They can become involved in the task of identifying how these phenomena are manifested in their case, rather than feeling they are being assaulted piecemeal by the therapist who keeps unpleasantly surprising them with new interpretations of their own behavior that they thought they understood.

These aphorisms border on what Havens (50) refers to as "performative" (or "counterintrojective") language; statements that perform an action simply by being spoken. Many such statements constitute an appraisal, a duly constituted authority ruling on a question of status (the umpire: *You're out;* the jury: *Not guilty*). Depressed patients are their own worst critics, and much of the therapist's work is aimed at counterintrojection, attempting to engage the patients' ego in looking objectively at the workings of their own punitive superego. *You're very hard on yourself. You're more skilled than you realize. Is it possible this was not all your fault?* In these aphorisms, the therapist uses his/her authority in an attempt to modify patients' status vis-à-vis their depression, to move them from the supine position to a questioning stance, then on to an active engagement with the condition.

Table I. APHORISMS OF DEPRESSION

Problems and symptoms are not the same
Depression is a disease
If I change what I do, I can change how I feel
I need to reconnect with my emotional life
I need to identify and correct self-destructive thinking and behavior patterns
I need to let my guard down
I need to learn to take care of myself
I need to practice detachment
Change can come from anywhere
There is a part of me that doesn't want to get well
I am more than my depression
Depression is a social problem

"Problems and Symptoms Not The Same"

Some patients contact us in emotional distress, or because they are unable to sleep, or have intrusive thoughts of suicide, or other symptomatic manifestations of depression. Others are primarily troubled by problems in living—they are not getting along with their spouse, they cannot make decisions, their own bodies are in rebellion. Most depressed people have a mixture of both kinds of troubles.

Likewise, most patients understand intellectually that they are unlikely to get lasting symptomatic relief without fixing the problems that are causing them stress, and also that their own symptoms are getting in the way of fixing their problems. So, although individual priorities vary widely, most people acknowledge that they need help that addresses both kinds of issues.

But this distinction is also a source of much resistance to making real change. Patients who are troubled primarily by symptoms are too likely to look for medication, or some advice or interpretation by the therapist, to be a magical cure that will require no effort on their behalf. *They want to be changed.* Patients who are troubled mostly by problems are too likely to assume that if only circumstances in their lives change, they can feel better without having to change themselves. *They want others to change.* Few come to treatment fully ready to change themselves.

Focusing attention on the tension arc between problems and symptoms keeps patients off balance in a stimulating way that prevents them from taking a rigidly defended position. It is also vital to keep the focus on things patients can do something about. When we talk about symptoms, we should talk about self-control and self-care; in essence, we are turning

the management of symptoms into problems. When we talk about problems, we need to reinforce the distinction between problems that can be altered and problems that simply must be accepted. Patients who are too highly focused on symptoms must recognize that recovery from depression comes from taking charge of their own lives. Patients who are concerned about problems they can do nothing about need to understand how their overconcern makes them symptomatic in ways they are probably unaware of.

"Depression Is a Disease"

At this point in our experience of treatment of depression, it seems equally naïve to believe that it can be "cured" permanently by either taking a pill or through perfect psychotherapy. The recurrence rate is too high, and even those who have a nonrecurrent major depressive episode usually lead damaged and diminished lives (5, 51). We can give patients hope that by taking care of themselves they can be among the number who maintain recovery; but by not warning them of the odds we infantilize them and deprive them of knowledge they need in order to make good life decisions. A case could be made that it is malpractice not to inform patients about the odds of recovery.

Schuchter et al. (49) present a detailed plan for applying the disease model for practice. The authors acknowledge that depression is associated with regression in many areas of functioning, and argue that it can be helpful to patients to contrast regressed functioning with the more adaptive and healthy functioning that they are capable of when not depressed. A tool such as Erikson's (52) familiar hierarchy of developmental stages can help identify areas that do not immediately present themselves as issues. The point is not to expect that patients can be cured of depression and, therefore, become capable of healthy functioning permanently and consistently; but that they can strive for more adaptive functioning even during an episode, and this achievement can be a source of great pride and strength.

But if depression is a disease, it is a very unique one, and the therapist and patient must communicate carefully and clearly about its nature. The primary benefits of the disease model are to help patients recover from the self-blame that accompanies depression and to develop hope through recognition that the disease has a long course but does not mean never feeling well again. The risks are that it can reinforce passivity, hopelessness, and helplessness—patients can conclude that only a miracle of science can save them. In that sense, depression is a disease like alcoholism—the only real cure comes from changing one's own behavior. Patients are certainly

not to blame for being depressed, but unfortunately they are largely responsible for their own recovery. Another analogy is of people who have suffered physical disability. What happened to them is tragic and unfair, but they have no choice except to learn new skills in order to help themselves get through life. Once they do, their chances of having a happy and fulfilling existence are generally no different than those of anyone else.

Another advantage of the disease model is that it helps patients stay alert to recurrences. Despite our best efforts at teaching patients to identify symptoms early, depression remains able to sneak up and capture them. It may be useful for patients to periodically perform a self-assessment like the Beck Depression Inventory (53) or a special adaptation of such an instrument geared to their idiosyncratic presentation; or to enlist loved ones in identifying the prodromal indicators of the disease. An early warning system can help patients prevent what might be a minor episode from turning into full-blown depression.

"If I Change What I Do, I Can Change How I Feel"

"Move a muscle, change a thought" is an old Alcoholics Anonymous maxim. It might be more appropriate to say "Change a feeling," but AA has historically tried to steer clear of emotional language. The point is that how we are feeling is directly affected by what we are doing. When patients are stuck at home, depressed and feeling worthless, unable to accomplish anything constructive, simple acts like taking a walk, listening to some music, or playing with the dog can often lift a mood. Sometimes the change is not enough to say that patients are no longer in a depressed state, but often it frees them up from their anger and frustration and enables them to move on to something more productive, which can lead to further change, and eventually to a real lift from the depressed state.

Vignette 2

Matthew, a 60-year-old businessman, was unhappy with a planned change in his employment status. He was the manager of a large family business and in the process of retiring. When I first saw him, his skin was an unhealthy gray and he looked exhausted.

He was referred by his physician because of "stress." He described poor sleep and a constant feeling of fatigue. He was in a persistent sad mood and described feeling detached, not caring about the things that usually were important to him. He reported that this had been his state for some time, but things were particularly stressful at work at the time of consultation. He worked 60–70 hours a week, as he had always done, but he was turning over the day-to-day operations to a new generation in his

family so that he could have time to devote to his other interests in life. This was a change he wanted very much, but he found that it was harder than he thought to give up the daily adrenaline rush that comes from being the center of a complex and changing operation. Although he had been known for his ability to handle stress, within the past year he had lost his temper a few times, lashing out at people who were not pulling their weight. He was extremely embarrassed by these outbursts. He had also recently been feeling as if he were kidding himself about his new interests, that they were really trivial and unimportant and he would live out his retirement in meaningless pursuits. He reported being withdrawn from his family, just wanting to be left alone to read or watch television.

After the second session, I suggested that Matthew start using the Mood Journal. He turned out to be an observant reporter. He noticed that each day during the week, as he trained the two people who were to take over aspects of his job, he became depressed and agitated. He felt that despite his intelligence, competence, and experience, they were not "getting it"—making obvious errors in judgment. In typical depressed fashion, he blamed himself ("I must be a lousy teacher") and catastrophized ("This was a stupid idea, it'll never work, I'll be stuck in this job all my life"). He would either lose his temper and be ashamed of himself, or withdraw and sulk. He noticed this pattern on four successive days. On the fifth day, when it started again, Matthew excused himself and went for a walk (without any prompting by the therapist). He deliberately challenged his assumptions, telling himself things like "I *am* a good teacher, they *can* get it, they have to do it their way, I have to let them make mistakes." He came back and went through the day's training without getting depressed or upset. His improved mood lasted through the day, and he noticed a change in the evening too. Trying to wrap Christmas presents and becoming all thumbs, he laughed at himself instead of getting angry or giving up. His wife noticed his improved mood and offered to help out. They put some music on, finished wrapping, and had a pleasant evening together—the first in several weeks.

We continued treatment with sessions every other week for about a year. Matthew was successful in handling the transition to a new role in life that was much more rewarding for him, and he took action in helping other family members with problems of their own. He referred many times to what he had learned on the day he went for a walk. For him, it was a very important realization—the equivalent of a "eureka" experience—that what he did could change his mood. Going for a walk and rehearsing a different interaction helped him change his behavior, and that in turn

improved his state of mind. We were careful to point out that there was no guarantee—he could not be sure that he could always change a mood—but knowing that it was at least sometimes possible was a revelation that he never forgot.

Some patients seem to be very impressed and hopeful at the news that psychotherapy can apparently result in changes in the brain that are visible by positron-emission tomography (PET scans; 54) or changes in brain metabolic rate similar to those caused by antidepressant medication (55). People seem willing to buy the idea that depression is a manifestation of a change in the brain that can be altered by medication. But most people seem to assume that while the brain can do bad things to us, we cannot do good things to the brain. The idea that life experience can actually make a change in the way the brain functions is potentially full of power and meaning for depression; it will just take some concrete success experiences before the depressive can begin to believe it.

"I Need to Reconnect with My Emotional Life"

We want to make it explicit to patients that depression is partly the result of a misguided effort not to feel, and to remind them that emotions are nothing to fear. We can take it as a working hypothesis that mood changes are typically caused by an effort not to feel an emotion, and much of the work of therapy can focus on exploration of those connections.

Patients are often confused by this proposition; they believe that they suffer from an excess of feeling, an excess of despair, anger, hopelessness. They fear that if they feel more, they will be unable to bear it. It is important to point out that they are feeling depression, which is an illness, whereas emotions are natural and inevitable. Most will acknowledge the difference between, for instance, sadness and depression, recognizing that a good cry prompted by a sad movie or powerful music can lift a depressed mood. With practice, including use of the Mood Journal, patients will learn that emotions not only do not have to be frightening, they also add spice and color to life. Unless patients can reestablish contact with the emotional side of their nature, the anhedonia of depression will never lift.

A certain number of depressed patients will report that they feel equally depressed all the time, with no fluctuations in intensity. This is a defensive maneuver that can be hard to overcome in the initial stages; patients may fear that if they admit to any relief at all from their suffering their pain may be dismissed, or that the therapist will use that information as ammunition against them somehow: *See, you're not really so depressed, are you?* A useful technique is to ask when the depression has been at its absolute worst: *Are*

there times when you feel even worse than you do right now? Once patients have been able to acknowledge this, then it is possible to begin to track changes in mood. *We understand that your depression is always 9.5 on a ten-point scale, but sometimes, apparently, it gets even worse than that. Let's see if we can gain some understanding of what makes it worse.*

"I Need to Identify and Correct Self-destructive Thinking and Behavior Patterns"

The tenets of cognitive-behavioral therapy for depression are well established in validity and utility (43, 56, 57). At every session, the therapist and patient should review the patient's progress in identifying and correcting these patterns. The therapist is deliberately trying to reinforce knowledge acquisition and habit strength on the patient's part. In effect, we want patients to become more objective observers of themselves. They can be encouraged to read any of several helpful popular books to add to their knowledge of depression (42, 58-61), and discuss their new knowledge with the therapist.

- *Perspective.* We assume that patients see the world through brown-colored glasses and need to make a self-conscious effort to correct for their habitual cognitive distortions—to develop awareness of opportunities for joy, to train their eyes to see more flowers and fewer weeds.
- *Assumptions.* Patients have built an assumptive world (62) on the basis of their skewed perspective. They need to develop and maintain awareness of their own particular destructive assumptions and either challenge them logically (*What's the basis for believing that?*) or test them empirically (*What if I act* as if *I were not helpless?*).
- *Logical errors.* We want patients to develop greater awareness of their own unique logical system that supports depression. When they come in reporting that they noticed how they catastrophized a situation or took excessive responsibility, we want to acknowledge and affirm their developing self-awareness.
- *Distorted perception of the self.* People with depression need to practice paying attention to positive feedback, to question their assumptions about their own role in events (bad things are always my fault, good things are always dumb luck, etc.).
- *Automatic negative thoughts (ANTS).* Many patients learn to take delight in spotting ANTS (63); once they learn to identify the process as something outside themselves, it becomes a sort of game to develop awareness of its many manifestations. Countering the

thoughts with empirical questions or positive affirmations almost becomes secondary to the enjoyment of identifying the sneaky bastards at work.

- *Work habits.* Procrastination is one of the principal behavioral manifestations of depression. We want to continually reinforce the application of basic organizational skills like learning to reward the self for effective work, developing stimulus control over problem behaviors, and establishing priorities (64, 65).
- *Assertiveness.* People with depression rarely have a clear idea of mutual rights and responsibilities in relationships, from highway driving to raising children to working with colleagues in an office. Active treatment of depression makes this deficit explicit, and reinforces the patients for learning and implementing assertive skills (66).

"I Need to Let My Guard Down"

A key element of depression is the fear of intimacy. Depressed people believe themselves to be deeply defective, and fear that if others knew them as they know themselves, they would be rejected and scorned. So they keep up a mask for the world, pretending to be happy when they're not, pretending to be competent when they feel like they're falling apart. At the end of the day, if they are successful at this all they get is the conviction that they can fool people easily, which just reinforces the depression.

At the same time, people with depression feel a desperate need for love, respect, and affirmation, but their pretense makes it impossible for them to believe that anyone can know or love their true selves. As patients begin to let their guard down bit by bit they learn that others are not repulsed by their feelings. They begin to understand that they are not really so different from other people, that the crippling shame they feel about themselves is far out of proportion to the reality of their "awful secrets."

The therapist needs to actively and directly identify that the fear of intimacy perpetuates depression, and help patients practice intimacy. This means identifying persons and situations in the patients' world that are relatively safe and trustworthy, and encouraging patients to begin to let their guard down a little at a time. This takes practice, patience, and a forgiving attitude from both patients and the therapist. The therapist will not be omniscient; some of the patients' forays into intimacy will not turn out well, and they will be hurt. It may be an opportunity for patients to learn that the hurt of real rejection is no worse than the hurt of imagined

rejection—but it will hurt, and the therapist and the patient must trust each other.

At the same time, the therapist must do everything he/she can to ensure that patients' efforts are successful. This can mean very detailed analysis of people in the patients' lives, their actual behavior and their behavior as seen by the patients; of the patients' presentation of themselves, their ability to size up a situation objectively, as well as their ability to shoot themselves in the foot. It means teaching patients the distinctions between letting their guard down appropriately and spilling their emotions too freely. It means discussing small talk, helping patients learn how people signal each other about what it is acceptable to talk about and what is not. In essence, it means being as wise about people and the world as possible and being willing to share that wisdom with one's patients.

"I Need to Learn to Take Care of Myself"

The continuing challenge for depressed patients is to learn to treat themselves as if they are worthy of respect and love. By stating the problem this way, we make it explicit that bad self-care perpetuates the depression. I have a list of areas of self-care (Table II) that I have found to be problematic with most patients, and we go over this list periodically during the course of treatment. I encourage patients to add to this list as they identify particular areas where they neglect or abuse themselves. This

Table II. BASICS OF GOOD SELF-CARE

Exercise moderately but regularly
Eat healthy but delicious meals
Regularize your sleep cycle
Practice good personal hygiene
Get help for painful conditions
Don't drink to excess or abuse drugs
Spend some time every day in play
Develop recreational outlets that encourage creativity
Avoid unstructured time
Limit exposure to mass media
Distance yourself from destructive situations or people
Allow yourself to feel pride in your accomplishments
Listen to compliments and expressions of affection
Avoid depressed self-absorption
Build and use a support system
Pay more attention to small pleasures and sensations
Challenge yourself

exercise may sound simplistic or demeaning to therapists who practice from a different perspective; again, it is part of an approach to identify depression as an active agent—an enemy—and build an alliance with patients against it. It's the depression, not the patients, that makes them not brush their teeth or watch too much television.

"I Need to Practice Detachment"

At the same time that depressives need to cultivate the ability to feel, they also need to learn how to detach from their emotions. Detachment implies recognizing and acknowledging feelings but exercising some conscious control over how much we let them affect us. It suggests a certain passive, observant attitude toward emotions: An understanding that our feelings come and go, that they are subject to distortion and contagion, but that they have limited impact on our core selves.

Much of depression seems to come from an obsessive quality that won't let patients detach from the immediate turmoil or problem they are faced with. Unable to stop, calm themselves, and objectively assess the situation, they are stuck doing only more of the same kind of ineffective intervention that keeps getting them in trouble. Frantic to fix the engine, they try to replace the bolts with a pair of pliers instead of going to get a wrench, and end up stripping the bolt head and skinning their knuckles.

The therapist needs to help these patients distinguish between what is truly important and what merely feels urgent. *Will this really matter next week? Is this how I really want to spend my time? What about this problem is realistically within my power to address, and what do I just have to accept?* Detachment is a highly underrecognized skill; we have to help patients learn to appreciate its value and help them practice its implementation. Mindfulness training (67), focusing (68), meditation (69), or any rhythmic exercise (70) can help develop detachment skills.

"Change Can Come from Anywhere"

Depression is a vicious circle (71–74). One of the great advantages of recognizing its circularity and abandoning linear causality is the realization that a circle can be broken at any point.

Most patients think about depression as having a single cause: their job, their spouse, their serotonin level, their difficulty sleeping. Discussion of the circular nature of depression can challenge that linear thinking without putting patients on the defensive. If we say *No, it's not your job stress, it's your* response *to your job stress that's the problem*, we are likely to raise all the patient's defensive anxiety about change and being blamed. However, if we say: *You're caught in a vicious circle that perpetuates itself; but it's*

possible that if we can just help you sleep better at night (or play with your children more, or treat your wife better, or change some of your depressogenic assumptions), you won't feel the job stress as so overwhelming anymore, the patient is more apt to give our suggestions a try.

Acceptance of this premise also gives patients hope and engages their creativity. They may be able to see that, while their head-on efforts at trying to control their problem have been getting nowhere, if they step back, look around, and examine the whole system, there may be other, more indirect, approaches to the problem that can yield better results.

"There Is a Part of Me That Doesn't Want to Get Well"

It can be helpful to simply state this at the beginning of treatment: Most people with depression want to feel better but are going to be afraid of doing some of the things necessary to feel better. The same skills of depression that ironically contribute to the existence of the problem will be activated even more strongly when they try to change the problem. Many patients will resent the idea that they have to change anything to get relief; after all, they certainly did not wish this condition on themselves. Most patients will acknowledge that they sometimes have moments of sanctimonious self-satisfaction, as if they had earned the right to be depressed. Many feel comfortable with depression as a familiar and safe place of retreat and self-indulgence. Acceptance of a depressed state means that patients have been able to give up trying for success and focus instead on preparing for future disappointments. These "resistances" should be presented as an expectable part of the syndrome of depression, which contribute significantly to patients' guilt and self-blame.

Naming this resistance in a matter-of-fact, objective way at the beginning of treatment has enormous advantages over waiting until it is manifested and then pointing it out to the patient. For one thing, patients are alerted to the problem (and also warned that *we* are alerted to the problem) and will be more likely to notice and acknowledge it themselves. We can positively reinforce such noticing on the patients' part, contributing to the overall tone of respect and collegiality we want to maintain. The patients' view of themselves as active and capable agents is reinforced. Conversely, if we wait until patients manifest resistance to change, and then pounce on it, we only reinforce their sense of guilt and inadequacy, and we make them defensive. They will want to argue with us, instead of considering that we may have a point.

We have to help patients develop awareness of the advantages and disadvantages of the sick role (41). It can be comforting; it can elicit

sympathy and pity, which can be effective ways of getting some needs met and provide a sense of emotional closeness and support. But it also reduces one's self-esteem and ability to function, and in the end it drives others away—pity is not love. Patients must develop an awareness of the paradoxes of the disease model of depression: It *is* a disease, but one in which we have to take responsibility for our own recovery.

"I Am More than My Depression"

If we take too narrow a focus in the therapy, restricting our vision to the manifest problem areas in patients' lives, and then concentrate only on how they contribute to the problem, we unwittingly reinforce their negative world view—that life stinks and it is their fault. This is an easy trap for us to fall into because in many ways it seems respectful of what patients want and it also pleases managed care.

We need a more complete relationship with our patients; we need to be interested in parts of their lives that are not the direct focus of treatment, and we need to have a relationship that is characterized by genuine interest, humor, and warmth. We need to be ready to play with patients when it's appropriate, to talk about mutual interests in a mutually respectful way, to let ourselves be known a little when it suits the therapeutic purpose. We need to practice phrasing our interventions in such a way that they give credit to the patients' strengths as well as exploring their weaknesses. Patients are all too ready to believe that depression is a trait they carry within themselves that poisons all interactions all the time. We need to continually point out that there are times when patients function more effectively than at other times, that when they are not functioning at their best there are good reasons for it, and that understanding those reasons means that change is possible. In Freudian terms, we take on the role of a forgiving and tolerant object to counteract the patients' internalized punitive superego. In self-psychological terms, we provide affirming and mirroring responses and permit these patients to use us as a reliable selfobject, gradually internalizing our accepting attitude (32). In constructivist terms, we diminish our status as an authority, step out from the safety of the rigid therapeutic frame, and engage with patients in dealing with the vagaries of life (75).

As soon as the worst depression begins to lift, patients should be expected to stretch themselves a little. *Do one difficult thing every day. Call a friend, volunteer, express an opinion, be generous, take a chance.* Depression is not only an illness, but a failure of creativity. We all share the problem of creating meaning in our lives. Patients need to find ways to be

fertile, to grow and produce, to have an impact, if they ever want to be free of depression.

"Depression Is a Social Problem"

It is extremely helpful for patients to realize that depression is not just a disease within themselves but a condition that is an intimate part of the social fabric of contemporary culture. Some patients know this already and want to set the therapist up as the voice of convention so that they can argue that society has contributed to their depression. But there is no value in trying to be a blank screen and disputing the subject; it's simply a statement of fact. I do not want to lift the responsibility for helping themselves off the patients' shoulders but I do want to help them understand that it is not by any means all their fault. In doing so I emphasize four points:

- *People with depression suffer from discrimination.* The stereotype that depression is a sign of weakness is a lie, yet others use that stereotype to make patients feel guilty and afraid of asserting their rights. Health insurance plans practice open discrimination by offering separate, more limited, benefit packages for mental illness. Discrimination against people with depression in schools and workplaces is the rule, not the exception.
- *Depression is reinforced by contemporary culture.* Mass culture makes values more shallow; beauty and financial success are prized more highly than honesty, dependability, intelligence, or self-sacrifice. Yet beauty and success are attributes that are distributed by luck or accident of birth more than by ability or effort. When depressed patients feel isolated socially or unsuccessful financially, not only do those states have their own inherent negative effects, in Western culture they imply a deep personal failure, an inadequacy of the self.
- *Depression is an epidemic,* at least in part because of cultural change that goes unacknowledged. We don't have a substitute yet for the family, but the family has fallen apart. Children lack the security they need to form stable attachments and develop self-esteem. We're all working many more hours and have less time available for our loved ones and ourselves, but the media ignore that fact. Our culture values competition over cooperation. There is more than a shred of truth in depressive realism: Relationships are full of disappointment and conflict and people are unhappier than ever. We need to make conscious and sustained efforts to rebuild a sense of community.
- *Everyone needs help.* Self-reliance is overrated. We rely on our

connections with others to give us a good feeling about the self, to remind us that we are real and that our lives have value and meaning. Yet from Sigmund Freud to John Wayne we have been taught that autonomy is the highest virtue, that intimacy implies dependency. No one can pull himself out of depression by his own bootstraps.

CONCLUSION

Depression is more difficult to recover from than either the mental health professions or the general public acknowledge. I have discussed two tools that can be added to the therapist's armamentarium to help make recovery more likely and more permanent. But the therapist's attitude about depressed patients and their disease is even more important. When patients are trying their best but their environment is not rewarding them, one obvious alternative source of reinforcement that we have near at hand is the therapist him/herself. Most depressed patients acutely desire the therapist's approval, and it is an effective therapist who gives it warmly and genuinely. I alluded in the introduction to the therapist's need to serve as cheerleader, a phrase which I am sure made many wince. But let's be honest. We know that we shape patients' behavior by showing interest and approval or showing boredom or condemnation. And we know that we can do this very subtly. In Wachtel's (71, p. 256) phrase, "a half-conscious glance at the clock or an intermittent brushing of lint from one's trousers can serve the very same function as a 'very good' or a 'that's wrong.' " While there is nothing worse than insincere praise, or praise over something that doesn't fit the patient's particular value system, a smile, a nod, an indication that you recognize the patient has accomplished something difficult, an indication that you share the patient's valuation of what he/she has accomplished, an emotional mirroring of the patient's pride—these can have powerful impact on the depressed patient. Particularly in working with patients who are competent, hard-working people whom we like as individuals, it is ironically easy for us to be insensitive to the effect a few kind words can have. What we do in the consulting room can lift a depressed mood, give the patient renewed energy and motivation, inspire confidence, reduce shame, open doors to new solutions—it is a great responsibility, and we should use it with skill and deliberation.

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