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PUTTING IT TOGETHER WHILE FALLING APART

A PERSONAL VIEW ON DEPRESSION

Abstract: The “two-pillar” approach to clinical treatment for depression, that is, medication and dynamic psychotherapy, has proven to be of limited success. I articulate a multimodal approach to treatment based on three lines of evidence: 1) my own experience with depression, 2) my experience as a group therapist for severely depressed persons, and 3) an analytic case of a depressed and suicidal woman. We need to seek remedy in disciplines other than traditional psychotherapy, including exercise, altruistic endeavors, group experience, and spirituality, all of which are worthy of more rigorous study.

Keywords: depression, dysthymia, proactivity, interpersonal psychoanalysis, operationalism, spirituality

ALTHOUGH NOT HIMSELF A MENTAL HEALTH PROFESSIONAL Andrew Solomon has earned his place as a national advocate for the improved treatment of depression and as a major voice on the topic. Anyone who is interested in a compendium of the most significant and terrifying aspects of depression and the many treatments available should read his compassionate and beautifully written book (Solomon, 2001). His telling of his own journey through depression, as well as similar journeys of close friends, even those of strangers, is a virtuoso demonstration of the reporter/generalist's style. His willingness to be so candid in this role makes his writing both visceral and trenchant. *The Noonday Demon: An Atlas of Depression* has immensely expanded the visible landscape of depressive disorder.

A skilled reporter/generalist must also be an integrationist, a role that Solomon eagerly accepts: “There was chaos in the kingdom; these different schools of wisdom were not integrated and they were not united” (this issue). Integration means effectively bringing together all the disparate disciplines that have anything to say about depression. Solomon's writing

makes significant headway toward a critical synthesis that includes philosophy, neurology, psychodynamics, autobiography, self-help, economics, theology, demographics, neurology, sociology, even history.

As a psychologist/psychoanalyst, I share with Solomon a compelling interest in depression. I, too, have experienced severe and prolonged depression. My voice is informed, additionally, by a background in cognitive behavioral training and experimental psychology. Thus, I take my responsibilities as an integrationist very seriously.

My approach is rooted solidly in the theory in which I was trained and the practice I have pursued for 30 years as a psychoanalyst. I relinquish nothing from this approach, but I do reject it as a "monosolution" for the treatment of depression. I believe that successful resolution of the disorder requires attention, first of all, to what I call "proactivity." This puts both power and responsibility in the hands of the patient to function as his own change agent. I am convinced that therapeutic efforts will not produce sustained benefit without this essential ingredient. Under the rubric of proactivity, the involvement of the patient in his own recovery, there are four modes of activity or personal attention that I recommend: 1) exercise and diet; 2) volunteerism and service; 3) participation in a support group; and 4) openness to some form of spiritual practice in the broadest sense of the term. The elaboration of these ideas and my reasons for them is the purpose of this article.

My Story

It was both my good fortune and my misfortune to experience depression from the inside. From September 1996 until the spring of 2000, I suffered from a moderate depression that would be technically described as dysthymia. Yet no diagnostic label could capture the bleak state I struggled through. My sense of selfhood was demolished while I fought to carry out my professional responsibilities as a therapist. I questioned my right to collect money from patients when I was clearly in as bad shape as they were. I lost confidence not only in myself but in the world. Convinced that other people understood things much better than I, I feared making significant decisions without consulting friends and colleagues. Mark Twain once said, "You wouldn't care what people thought about you if you knew how little they actually thought about you." I felt the opposite was true for me. I believed that everyone was weighing and measuring what I said and thought it was stupid. I watched my wife's career take off

while mine was in the doldrums. Would she lose interest in me? Would she become dazzled by some younger, more enthusiastic man, a colleague perhaps, and leave me in the dust? In that case, I was certain I would no longer be able to “compete.”

It seemed that my brain was operating much more slowly than before. My memory, in particular, was shot. I would get stuck in the middle of sentences because I couldn't remember the right noun. A lifelong problem retrieving names got noticeably worse, and I feared if I met patients out in the street I would not remember who they were. I began compulsively writing down details to be sure I could keep things straight.

Nothing excited me. My habitual curiosity abandoned me. Life plodded along in a dismal routine, yet routine was all I could tolerate. Evenings brought mild relief, as if I had magically survived something horrible. Then my crippled sense of humor might make an occasional appearance. Although I was only in my 50s, I thought of myself as a retiree. I risked nothing and was overly careful crossing streets. Worried about chills, I started wearing an overcoat on mild days as if it might protect me. I could not imagine a better future and would say again and again, “Just face it; life is a struggle. Aging only makes it worse.”

I had great difficulty falling asleep at night and seldom woke up feeling rested. Because elevated blood sugar provided at least transitory mood lifts, I found foods rich in sugar and trans fats especially appealing and managed to gain 16 pounds over my normal weight. In short, I felt as if I were on an inexorable downward path. My malady was Life itself. It seemed sterner and harsher than ever before, and I was running out of energy for it.

I could manage to role play through social events and did indeed fool many people who were close to me. Years later, when I told my sister how relieved I was not to be depressed any longer, she expressed surprise. She never knew how low I felt during those years. All the while, I had wondered how this could all be happening to me: *Physician, heal thyself!*

During that same period I was taking a medicine called Interferon for a chronic liver problem. Intellectually, I understood that this medication could cause depression. A majority of people taking Interferon are on some form of antidepressant, usually Wellbutrin. Perhaps it was because of my depressive condition that I did not think I needed antidepressants. I could not relate my mental state to the side effects of Interferon any more than most depressed people can relate their depression to faulty brain chemistry.

At the insistence of my doctor, I finally did try antidepressants: Wellbutrin first, then Prozac, and finally Zoloft. But I could not tolerate the side effects of any of these medications. I stopped them before the benefits had a chance to kick in. Because depression was not the diagnosis I had given myself, I was, of course, not surprised when the medication failed. I thought my problem was simply a “failure to pick myself up by the bootstraps.”

This harsh self-criticism prodded me to become more disciplined, and I tried to deepen my commitment to certain already established practices, like exercise. When I doubled my workout time, it seemed to give me something to do. It provided distraction from the chronic worrying, at least while I was in the gym. Surprisingly, after a few weeks, I seemed to have more energy and was sleeping better at night. This lifting of my spirits gave me a much-needed perspective: I came to realize that I was indeed depressed. From this glimmer of insight, I began to grasp the darkness I had come from. This was an important beginning. It was, however, some time before I came to appreciate the vital role that physical activity played in it; I thought it was my decision to shape up emotionally that had restored balance and lifted denial.

When I finally admitted that I was depressed, the disorder suddenly seemed tangible and visceral. I felt as if a virus had invaded my system, or a curse. I would have welcomed an exorcism. Willing to accept that I was not the self I thought myself to be, I began to seek relief in whatever form it might appear.

I experimented freely now with other activities, some borrowed from self-help books and some the product of ramping up my own intuition. Success was inconsistent. On the recommendation of friends, I tried taking long walks among the trees. This activity failed miserably, I think because those solitary rambles gave me more time to ruminate and obsess about my troubles.

One effort, however, had a rapid and remarkable effect on my functioning and disposition. In the second year of my depression, I was asked by a close professional colleague to take on as a volunteer the running of a support group for gay men whose lovers had died of AIDS, or who were caretakers of men dying of AIDS. The work was challenging, emotionally and intellectually (O'Leary, 1997). I became so totally involved in its demands that preoccupation with my depression was lifted for sustained periods of time. Listening empathically to the patients in my group put my own suffering into sharp perspective. It made me feel I was doing something

important, making a contribution, and that I had a useful, human purpose. Rather than my being further depressed by the truly awful stories I heard, they dramatically improved my mood and increased my reserves of emotional energy. I congratulated myself for choosing to take on this useful and humanitarian assignment but did not examine closely the therapeutic effect it was having on me.

The second strand of this story begins in December of 2002, two years after my depression was fully relieved. I was invited to run a psychotherapy group at Columbia-Presbyterian Hospital in New York for severely depressed people, many of whom were suicidal. Soon after, I decided to accept a part-time staff position there. Several of my patients had been recently discharged from psychiatric units. While their day-care program embraced a Dialectical Behavioral Therapy (DBT) model, nearly all the patients were in some form of dynamic psychotherapy, up to three times a week, and all were under the care of a psychiatrist. Each patient was stabilized with, on the average, four medications.

Despite expressing confidence that they were doing better in this well-monitored and highly structured program, they were terrified by the possibility of being rehospitalized. The questions the patients asked me again and again were: What else can we do? What else works? I quickly learned that every difficulty I had experienced in my own depressive episode was endured by these patients, albeit in greatly magnified form. I discovered that they experienced many additional symptoms. Some could hardly remember a time when they were not depressed. Suicidal feelings pursued them continuously. Many reported being unable to get out of bed in the morning, a task requiring more energy than they could muster. I found their courage both touching and inspirational.

The uncertainties troubling these patients, and their persistent questioning, encouraged me to reexamine my own depression and begin to find meaningful answers for them. I approached this venture systematically and, for the first time, became willing to consider the possible benefits of treatment modalities that lay outside my area of expertise. I read everything I could lay my hands on in both the allopathic or mainstream medical literature, as well as the naturalistic and alternative medical world. I was particularly eager to understand how group experience might have a more than merely supportive role in recovery. I wanted to examine with a scientific and clinical eye any kind of remedy these patients might report as having made some difference for them. At this point, I began to view my own experience in a new way. Instead of my trying to forget about it, my

personal battle with depression suddenly appeared as a rich mine of information that could be useful to me in my work.

While working with the group at Columbia Presbyterian, I was also seeing, privately, a severely depressed and suicidal patient, Sister (Sr.) Karen, who had been my patient for some years. Her case forms the third strand of my narrative and was perhaps the critical influence in shaping my thoughts on how to engage depression. In my work with Sr. Karen over a period of 12 years, I finally began to synthesize the approach that I am attempting to elaborate here.

I began seeing Sr. Karen well before I developed my depression. From the start, I handled her case within a traditional interpersonal psychodynamic paradigm. I was attentive to unconscious process, to enactments. I tried to build, with her help, a meaningful narrative. I self-disclosed on occasion and used my feelings during sessions as investigatory tools. I was practicing in a manner that was familiar and well within my comfort zone.

As I came to grips with my own depression, however, I found myself listening more closely to how Sr. Karen made it through her day. I could not ignore the fact that I was trying to find something instructive in the way my patient handled things. In retrospect, I see that I became less confrontational and more supportive of her during this time. Then, as my own depression began to subside, I was prepared to press her more for details and to be more challenging. I culled from her history the times and places when she seemed more actively engaged. I queried specifically why she had dropped certain activities or friends who had been important. Without making a conscious choice to do this at first, I studied the dynamics of her depression as a reflection of my own.

At the time of our first meeting in 1989, Sr. Karen reported a long history of hospitalizations. Her three attempts at suicide involved swallowing open safety pins. Both before and during these hospitalizations, she had been placed on the full array of medications available in the late 70s and early 80s, from antidepressants to antipsychotics like Thorazine. She claimed that none of these medications had helped her, that she experienced only side effects and felt "knocked out" most of the time. To this day she refuses any further psychotropic medication. During Sr. Karen's final hospitalization, she had been given a series of ECT treatments. As a consequence, she resolved that she would never allow herself to go back to a hospital again.

Sr. Karen had been raised in a family with several depressed members. She had joined the order of sisters to get away from her extremely depressed

and tyrannical mother. In such a religious household, this was the only acceptable reason for leaving home and the extraordinary burdens of Sr. Karen's caretaking role. She did, ultimately, return to civilian life.

Trust was a major difficulty for Sr. Karen. She demonstrated this by revealing to me after a year of treatment something I found shocking and extraordinary. For the entire period she had been seeing me, she was simultaneously also seeing her old therapist—to "test" us. She needed to do this, she said, to be certain I would not betray her, as she felt he had. Would I stop listening, stop caring?

Feeling deceived and furious at first, I eventually calmed down and had to acknowledge that I was playing a significant part in the charade. During many afternoon sessions I was bored by her rendition, fought to stay awake, and yet was reluctant to say anything to her about it; I kept it to myself. On her side, she was repeating the same story to both of us, perhaps striving for consistency (or not). It's no wonder she was boring! She was not fully "in" her story, because she was too busy monitoring both her analysts. If I had confronted Sr. Karen with my somnolent reaction to her, if I had pointed out her apparent lack of engagement, I might have nipped her deception in the bud. I saw that she had a valid point in not fully trusting me. I had not, in fact, been completely honest with her. Subsequently, we discussed this enactment many times, and Sr. Karen has never since been a "boring patient."

Like many depressed people, Sr. Karen had extraordinary sensitivity to humiliation and imagined that other people were taking pleasure in her damaged condition. Shame forces a person into hiding, as Sr. Karen hid by entering a convent at the age of 16. In deceiving her two therapists, Sr. Karen extended this secret life where no one could be privy to the whole truth about her. From the start, Sr. Karen had what Freud called an observing ego. She could look at herself and her behaviors from a reasonably objective stance. She was aware, for example, that her deception during the first year of therapy would be seen as neurotic, but felt compelled to go on with it anyway.

I explored another dynamic that I considered to be in the same category of behavior. When I asked Sr. Karen what made her feel balanced, protected, safe, or what she felt was most helpful in her difficulties, she would say it was the close relationship she had with Mary, the mother of Christ. Sr. Karen prayed constantly for Mary's intercession and insisted that Mary always walked by her side. I did not get in the way of this relationship, which is to say I did not interpret or pathologize it. Neither did

I examine it closely at that time nor consider its possible good effect. My dismissal of Sr. Karen's reliance on spirituality was automatic.

Sr. Karen still attends church services and prays directly to God because she believes that she is now "good enough" to do that. She no longer believes that her sins are "unpardonable." She credits therapy with helping her to understand herself better, for her no longer believing that she is evil, and for allowing her to believe in the power of her mind.

She has become a very good patient—she has developed a ready access to her darker feelings, including her hostility to me and the expectation that that I would eventually abandon her.

Until recently, I attributed Sr. Karen's improvement solely to the effects of psychotherapy. I viewed this patient solely through the lens of my training and I underappreciated the role of her spirituality. I can only now acknowledge, with some perspective on my own depression and after hearing countless stories from my group members, a profound change taking place in her about which I was in significant denial. In part, this denial is attributable to a bias I held long before I decided to enter professional practice, a bias I believe was reinforced by my analytic training.

Despite having grown up in a religious family, I was always skeptical of religiosity. During my early professional days working in the state hospital system, I neatly tied religion to delusional thinking. In those settings, I had before me the very cases that strongly supported this belief. I think I have come at least half-circle in these matters. In my own recovery from depression I did not "find religion," nor did I embrace delusion. I did, however, discover the efficacy of meditation and prayer and come to value the humility that these activities involve. I must now acknowledge the extent to which Sr. Karen's spirituality actually provided a critical underpinning to her survival from a damaging history and for her recovery in therapy.

Sr. Karen often reminded me about the service activities she relied on to keep her depression at bay, and I did not at the time fully appreciate these either. For example, Sr. Karen had a longtime role as caretaker to people around her. While a nun, she became quite attached to the elder sisters in the community. She visited them when they were sick; she brought them food and small gifts and celebrated birthdays with them. According to Sr. Karen, these activities brought much meaning and comfort to her life. Eventually, I made the connection that her beneficial experience of service paralleled my own as a volunteer with AIDS sufferers and with the suicidal population at Columbia Presbyterian.

That was not the only point of reference I began to see. Sr. Karen had never participated in exercise or even valued it until she was in her 50s and had become significantly overweight. When she moved to a community for seniors, she took up hiking. At around the same time, she became a subject in a drug experiment based in a local hospital. Accompanied by a flexible diet, the drug was meant to curb appetite. It worked. Between the two activities she was able to shed 40 pounds. So proud was she that she sent me a picture of herself. She reported feeling less depressed and more in control of things. She increased her hiking distance and chose more difficult terrains. She enjoyed her new hiking companions tremendously. Sr. Karen sounded better than at any time in our association and seemed to have found a lot to live for.

I began to see how my own experience with exercise mirrored my patient's. I became increasingly supportive of her physical regimen, and her proactivity. I was eager for any information she might impart to shed light on my growing curiosity about what went on in her life outside of sessions. Sr. Karen and I are both typical of those with serious depression. Like me, she was searching, trying everything on any thoughtful person's list of possible healing strategies. Each of those strategies was, in fact, making some contribution to progress. My major insight at this point was to see the activities as *direct causes* of the improved state, rather than as mere outcomes. Recently, I asked Sr. Karen how important her activities had been to her healing. Her answer was, "Incredibly important," especially the caretaking of others. She said, "This gave purpose to my life. I could not have recovered without a sense of purpose." At last, I believed her!

Synthesis and Integration

Had it not been for my own struggle with depression, I probably would have been satisfied in my analytic role to continue treating depressed patients within the traditional paradigm. Had it not been for my work with the AIDS patients, the suicidal groups at Columbia Presbyterian, and Sr. Karen, I would not have understood my own recovery. Those professional activities provided insight and far more. They sustained my continued improvement (by engaging me proactively) while demonstrating the importance of proactivity in real time. The catalytic effect of my personal experience and my analytic work allowed me to view depressive disorder from a more panoramic and, I believe, more functional perspective. The

different modalities, private and group work, created a wonderfully reflective environment for my ideas to evolve; everyone benefited.

An important component of depression is “hiding,” which stems from a deep feeling of shame and defectiveness. During my own depression, I felt so inferior to others that I disengaged from the social world. Sr. Karen was a skilled “hider.” I saw how being part of her religious community and her seniors group drew her out of isolation. I came to acknowledge, through her, the importance *to me* of having a support community. The extraordinary benefit Sr. Karen derived from volunteerism and her general inclination toward altruism also reflected on me. On a daily basis, I saw how volunteering, using my humanity and the very best skills at my disposal to help others, helped me.

My work with Sr. Karen also informed my group work at Columbia Presbyterian. Conviction grew strong that members helping other group members could be curative in its own right. No one was “completely defective” if he or she could help a fellow sufferer, and everyone had something to offer. It became clear that contact with other depressed persons, wherever they were in their recovery, made an enormous difference. It had been very difficult for me to accept Sr. Karen’s spirituality as important in overcoming her depression. But I observed that people in the Columbia group who reintroduced themselves to their churches or synagogues often obtained a degree of solace that had eluded them in both analytic and pharmacological treatment. I began to develop a meditative practice of my own, borrowed from some Buddhist experiences, and was finally willing to concede that it helped enormously.

This synthesis of experience and practice has convinced me that the phenomenology of depression goes far beyond any list of symptoms such as early-morning awakening, low self-esteem, or difficulties concentrating. I have no confidence either in the notion of an overriding factor, a metatruth, to explain the disorder: the loss of a significant other (symbolic or real), pervasive anger turned inward, or the sequelae of past trauma. I have seen depressed patients with all these issues, and some in whom none of them could be uncovered. On the other hand, I did find a distinct set of internal voices that signaled depression, sentences that a depressed person repeats to himself over and over again. I certainly did. “You are stuck here forever and will never get out.” “It is your own fault that you are here.” “It is the mistakes you have made and the bad Karma that you have created that have brought you to this place.” “Just admit it—you are defective. You are failing miserably to live

up to your own standards.” “You are an incredible burden to those around you.”

Those persistent voices are more devastating in their impact than are the symptoms themselves, which often wax and wane. Cognitive therapists have catalogued them as a set of beliefs or attitudes that rigidify this system. These include a tendency toward black-and-white thinking (e. g., the world is divided into winners and losers), tendencies to overgeneralize (e.g., a failure in this course means I am not college material), and a selective perception of the negatives in one’s life (e g., only a plastic surgeon will tell me the truth about my appearance). The destructive effects of such rumination cannot be minimized. Consider that depressed people fall prey to simplistic thinking, that they are often deep in rumination (Nolen-Hoeksema, Morrow, and Fredrickson, 1993) and therefore are unable to pay full attention, and that an important aspect of their memory processing has been noticeably curtailed, as in a loss of neurons in the hippocampus (Rajkowska, 2000). Is it any wonder that many depressed people are convinced they have lost significant IQ points during their illness?

An interpersonalist might construe this distorted view of the world as a position taken in life, a posture (Bose, 1995). It is rigid and impenetrable, as if the depressed person cries to anyone who will listen, “Leave me alone. Stop bothering me. I don’t see the point. Can’t you see?” To the person on the receiving end, that can feel like a stubborn refusal to cooperate, as if the depressed person were saying, “I won’t be turned on by anything you suggest. I won’t even engage you.” The consequence is that family, friends, and even therapists feel discouraged, helpless, and sometimes rageful. Spouses of depressed people have reported all these reactions (Sheffield, Wallace, and Klein, 1998), which further confirm for depressed people the bad view they already have of themselves. In this way, depression sets in motion a painful, vicious cycle that can also be contagious (Joiner and Katz, 1999). Everyone involved simply throws in the towel.

My view is that depression is a disorder of activity, that it is, in fact, an extraordinary and pathological passivity. Even in agitated states of depression, the person remains passive with respect to accomplishing real goals. I believe the first step in treatment is to get the depressed person moving, somehow active in the world and taking responsibility for that action. The term I favor is proactivity, although I can imagine other terms, like agency or self-efficacy. One must be active in the process of a cure if it is to fully take hold. This may appear axiomatic to any interpersonal psychoanalyst, but not to a large part of the depressed community of

19 million people, or to many of those who treat them. Solomon speaks of depression as a disorder of vitality, not of sadness, and I think we are on the same page here.

Let us not underestimate the state of paralysis that can take over the depressed person. Solomon (2001) provides the example of his extraordinary struggle with inactivity. He describes his effort to get out of the bed he had been lying in for three days. He resolved to divide the task into several steps, the first being to turn over and face the right side of the bed. The second, to position his knees so he could then lower his feet to the floor . . . and so on until after the third step, he falls back, exhausted and utterly defeated. In this disease of insidious and destructive passivity, every little thing is effortful and exhausting, as anyone who has known serious depression will agree. With the ministrations of his father and the help of medications, Solomon was finally able to get up—and in so doing jumpstart his life again. The “getting up” must happen, whether or not medication provides the first window of respite to assume a proactive stance.

Medication, however, cannot be the sole, or even the primary, solution. Martin Seligman's (1972) learned-helplessness model offers support for my opinion on this matter. In his early work with rats, he induced a state of helplessness by preventing their escape from a noxious situation. This led to a state of listlessness in the face of new problems. The animals were unable to try solutions that were clearly in their repertoire. The moral of the story: we may be reinforcing learned helplessness by relying exclusively on medication or anything else that does not contribute to a sense of personal efficacy.

I see personal efficacy, or proactivity, as the foundation for any successful approach to depression. Through empirical research, through the experiences of my patients, and, not least of all, through my own experience I find that proactivity is the component that holds a treatment plan together and potentiates all its elements. These include medication and psychotherapy, as well as such nontraditional activities as the practice of altruism, participation in a support group, and belonging to a spiritual community. Exercise and diet (targeted to specific neurotransmitters) play an important part in the successful treatment of depression, as well as the relearning of how to sleep. I believe that as patients become more able to take on such approaches, the greater the likelihood of improvement.

All this may sound like a lot of extra work for an analyst, and some of it may lie well outside an individual professional's comfort zone. But my assignment, as I see it, is to seize the opportunity given me to by professional and personal circumstances and make the case for my view as strongly and

convincingly as possible. This article is my first step in opening up what I hope will be a vigorous dialogue on the subject.

Biology and Experience in Depression

Research tells us that depression is to a significant degree, although not exclusively, a biological disorder. It runs in families. If you want a percentage, think between 40% and 60 % for genetic loading (Wallace, Schneider, and McGuffin, 2002). One enormous benefit of research into the biological basis for depression is that so many people have come out of the closet. They realize that having depression is not their fault or even their parents' fault, as inherited patterns have taken their toll through generations. When stress is significant or sustained (or both), the vulnerable individual will become depressed.

In this new era of brain-scanning technologies and scientifically advanced autopsies, evidence accumulates to prove that a part of the brain, the hippocampus, is in many cases shrunk by depressive disease (Sheline et al., 1999). Some parts of the brain show increased activity and others decreased activity. Data support not only that the brain alters with depression, but also that these same changes reverse when appropriate healing takes place (Chen et al., 2000).

Researchers recently have also discovered the intimate relationship that exists between heart attacks and strokes with the onset of depression (Rugulies, 2002). Some among us might write this off: "Well of course—a heart attack is a big thing and having one might get anyone down and depressed." But more than that is taking place. Depression can also serve as a signal that a heart attack or stroke is about to ensue. The "chicken and egg" question raised here strongly suggests that at some physiological level the two processes are correlated, especially in older people.

It is no surprise to most of us that the state of the body and the state of the mind are intricately linked. As therapists, however, we quite understandably tend to view the mind, the psyche, and the interpersonal field as the driving forces in pathology and as the only appropriate targets for intervention. Rather than thinking of it as "icing on the cake," I prefer to elevate the importance of the physical, especially food, sleep, and exercise, to therapeutic factors in their own right.

My search for an approach in the treatment of depression has led me to integrate into my practice several nontraditional components, including exercise, spirituality, and group experience.

Exercise and Depression

In the winter of 1998, at the lowest point of my depression, I made a discovery. In my world, which seemed so dark and dismal, stripped of self-esteem, I experienced fleeting moments of happiness after a vigorous aerobic workout. On the days I exercised this way, I worried less, concentrated longer, slept better, and even ate differently because I did not want to undo these effects by loading up with the wrong calories. This—call it euphoria—is well known to fitness buffs. But it came as a big surprise to this suffering depressive. As an analyst, I could not ignore the possibilities exercise suggested for the depressed patients I saw daily. I began to include it in my basic interview. I capitalized on opportunities to underscore the importance of exercise, especially in treating depression. I am now firmly convinced that regular exercise enhances mood, particularly for the severely depressed, and is one of the strongest pillars of a comprehensive treatment.

To find support for this view, I have examined many research studies but do not feel that the question has been answered definitively. I am not alone in the quest, however. Peter Salmon (2001) reports that, despite the positive results from hundreds of controlled studies as well as meta-analyses, where the results of several studies are combined, there is a notable lack of agreement on the specific biochemical precursor for mood improvement as a consequence of exercise.

I used to think, and I was not alone in this either, that small morphine-like substances, called endorphins, are released into the system during a vigorous workout and this is what made people feel so much better. I have discovered, however, that it takes a lot of sweat, much more than you and I are willing to expend on exercise, to achieve this effect. Some marathoners may never experience the so-called runner's high.

The most fascinating theory of the power of exercise was highlighted in a *Newsweek* (2007) article. New research has been hailed, most particularly the work of John Ratey (2008) at Harvard University. He reported evidence that both moderate and reasonably complex exercise (e. g., tennis) is responsible for improved efficiency of the brain by way of neuroplasticity as well as from the growth of new brain cells or neurogenesis. The big surprise here is neurogenesis. The concept of neuroplasticity (neurons connecting to different and more neurons), while interesting, has been around for quite a while. It is only very recently that the idea of growing new brain cells has made an appearance (Ernst et al., 2006). Brain cells

were thought to be fixed in number and doomed to die off over time (Eriksson et al., 1998).

In addition to this marvelous discovery, Ratey discussed how exercise causes the release of a brain-derived neurotrophic factor (BDNF), the key substance for promoting neural growth. This neural growth seems to occur in only two places, the hippocampal region and the olfactory bulb. It takes about a month before one can detect a difference, which is about the same amount of time it takes for the average SSRI to have an effect. Researchers need to attend more to the role of the hippocampus in the relief of depression.

The hippocampus is a horseshoe-shaped structure in the midbrain. It is known to be important for emotionally charged memory such as memories that are involved with trauma. This growth of new cells in that area could dramatically affect the ways these memories are encoded and might even reduce the grip of early life traumas.

Of course, these theories are works in progress; final word on the complex relationship among exercise, body chemistry, and depressive symptoms will undoubtedly require many studies, theories, and disciplines. Meanwhile, I continue to explore with the tools and experience at my disposal. What follows is not currently part of the scientific debate and lies more in the domain of personal insight as to why exercise works. No one can do it *for* you—or *to* you. I have argued extensively that a depressed person must regain a sense of being proactive, a belief that he is at the center of his own actions. In short, the depressed person needs to feel more in control of anything he can, in fact, control. Exercise is an intervention the patient can undertake that no one else can. The sense of empowerment it offers is critical.

Spirituality

I have come to accept spiritual practice, another developmental process, as therapeutic in its own right. I feel hesitant to raise this topic in a political climate so pervaded with religious fundamentalism. We need to bear in mind, however, that most forms of spirituality have little to do with imposing religious principles on others. By spiritual practice, I mean performing a set of rituals (prayers, meditations, hymns, readings, inspirational talks), alone or with other people, that involves honoring the transcendent. This “higher power” may for some people simply mean a profound belief in humanity.

Andrew Solomon notes in his article the negative shift in Western history when saint/scholars like St. Thomas Aquinas began to describe depression as a "sickness of the soul." In analytical work with depressive patients, it is difficult to avoid the conclusion that depression is a disease not just of the mind, but also of the body and the soul. While we have no difficulty seeing depression as a disordered mind, we balk at the very concept of soul and the individual's place in the universe. Yet our patients themselves express their suffering in terms of certain profound beliefs: "I am alone," "There is nothing in life to take pleasure in," "I am damaged goods," "I am cursed by my own mistakes." The urge to put an end to things can be seen not only as a reproach of the individual's relationships on earth. Patients grapple constantly with concerns about their place in the cosmos. It strikes me as arrogant to ignore this as indicative of a crisis of the spirit.

It is abundantly documented that depressed people can often lose their previous spiritual convictions when the full force of depression hits them. In an NPR radio interview with Krista Tippett on November 16, 2006 on her show, "Speaking of Faith," Andrew Solomon reported having found solace in the "hardness" of Judaism, a faith that emphasizes law, acceptance, and endurance as reflected in the Old Testament. Not a religious person, he confided to Tippett that Christianity, with its emphasis on compassion and forgiveness, would not have worked for him.

Faith offers protection, not a quick fix, and perhaps it does not matter whether this protection is illusory or real. The ability to make some personal connection to the transcendent lifts people out of the narrow world of their own concerns and can help break the spiral of negativity and passivity that characterizes depression.

Religious or spiritual affiliation can also have negative aspects. While religion is often a source of comfort, it can also promote the opposite. Severe stress, even trauma, can be experienced by a religious person as akin to alienation from God. Some suffer from profound conflicts with their religious beliefs (Exline et al., 2000), such as those whose lifestyle behaviors are considered sinful by their religious community (e. g., homosexuality). Having your deepest longings referred to as an abomination can be powerfully destructive of a sense of self and promote mood dysfunction. Many who have deep-seated religious beliefs yet suffer terrible personal tragedies feel abandoned by their God. Moreover, people engaging in fanatical or extreme religious behaviors seem to be at risk for depressive symptoms and disorders (McCullough and Larson, 1999).

The issues are indeed complex. Each case must be decided on its own merits, the positives and negatives given their due. I suggest that a tolerant and genuinely inquisitive attitude toward our patients' religious and spiritual convictions is the best approach.

Conclusions

My professional and personal experience leads me to conclude that depression defies any overriding causal explanation, any all-encompassing clinical description, and any single treatment methodology. My view of the disorder, from both the outside and the inside, supports the opinion that understanding and treating it depend on the integration of traditional and nontraditional methodologies. I am convinced that multiple perspectives and a diversity of techniques offer the best hope for success.

Genuine diversity would also embrace the rigor of operationalism in which no psychological finding is to be considered "true" that is not verifiable by replicable scientific method. In the operationalist universe, however, we analysts are urged to put aside attention to the unconscious, and even our narrative truths, a serious disadvantage in our profession. In the broad operational dominion, which includes most of the professional graduate training across the country, it appears that the matter has been settled and that psychoanalysis as a treatment modality for depression has been discredited.

I would like to see a more balanced and integrated approach. I think of operationalism as an *additional* tool at the analyst's disposal, albeit a critically important one. It is not the sine qua non for arriving at truth, but neither is it, as the postmodernists might suggest, an altogether different discourse. Operationalism deserves a place, but not at the head of the table.

My personal investment in underscoring the importance of operationalism is that I believe it should and will be the main avenue for recognizing that there is some value to the adjunctive treatments I am recommending. Indeed, this has already happened to a significant degree with some of the strategies I discuss here. There is a sizable literature on controlled studies for the value of exercise (Martinsen, 1985; McDonald and Hodgdon, 1991; Craft and Landers, 1998; Salmon, 2001); for the protective power of a spiritual program (McCullough and Larsen, 1999; Dein, 2006); and for the healing effects of participating in support groups (Yalom and Leszcz, 2005; Rutan, Stone, and Shay, 2007). The importance of altruistic

behavior has only recently been taken on by researchers (Musick and Wilson, 2003; Yunqing and Ferraro, 2005).

The divide is deep between psychoanalysis and operationalism. My guarded optimism for bridging this divide stems from the growing influence of neurology in psychoanalysis over the past eight years. This may accelerate a needed process.

I firmly believe that we, as psychoanalysts, have placed too much emphasis on a two-pillar approach in treating depression, that is, medication and dynamic psychotherapy. The problem is much larger and more multi-dimensional. The core of the approach I recommend helps a depressed person to get moving again by encouraging and supporting personal agency, or proactivity. This requires collaboratively setting goals in several areas that appear to be related to personal well-being. Powerful consideration should be given by the patient to the adjunctive strategies of establishing an exercise program, being part of a support group, finding ways of helping others, and locating a spiritual program that works for him or her. The critical difference underlying these recommendations is the belief, borne out in both my personal and my professional experience, that they do not merely make the patient feel better; they have intrinsic therapeutic potency.

We now need to study and experiment with these ancillary modes and techniques in the same way, and with the same vigor, that brought us finally to advocate medication. To derive the greatest benefit from this effort, we need to work more collaboratively with other disciplines. I am especially excited by the work going on in scientific psychology and in the new biology of the brain. Alternative medicine and sports medicine also deserve a place in the dialogue. We need to work in ways that enhance communication, for example, being more open to operational definitions that can be used to create testable hypotheses.

I am deeply appreciative of Andrew Solomon's contribution to the understanding of depression. He has alerted us to the magnitude of the problem, summoned us to be integrationist, and been willing to go outside the halls of psychiatry to ring a sounding bell that cannot be "unrung." Solomon is to be thanked for so vividly depicting the self-exacerbating exhaustion and loss of vitality that sit at the center of the disorder, as well as for the hopeful view he offers in his article in this issue.

The "feathers" to which Solomon refers in his title and that have lifted me away from my own depression are a deeper appreciation for living life meaningfully, for being engaged. Rather than seek happiness, I would

wish, as the poet William Blake said, “to kiss the joy as it flies.” I feel blessed that this profession has crossed my path with so many depressed yet courageous, creative and generous people.

REFERENCES

- Bose, J. (1995), Depression. In: *Handbook of Interpersonal Psychoanalysis*, ed. M. Lionells, J. Fiscalini, C. Mann & D. Stern. Hillsdale, NJ: Analytic Press., pp. 435–468.
- Chen, G., Rajkowska, G., Du, F., Seraii-Bozorgzad, N. & Manji, H. (2000), Enhancement of hippocampal neurogenesis by lithium. *Journal of Neurochemistry*, 75:1729–1734.
- Craft, L. & Landers, D. (1998), The effect of exercise on clinical depression and depression resulting from mental illness: A meta-analysis. *Journal of Sport and Exercise Psychology*, 20:339–357
- Dein, S. (2006), Religion, spirituality, and depression. *Primary Care and Community Psychiatry*, 11 (2):67 – 72.
- Joiner, T. E., Jr. & Katz, J. (1999), Contagion of depressive symptoms and mood: Meta-analytic review and explanations from cognitive, behavioral, and interpersonal viewpoints. *Clinical Psychology: Science and Practice*, 6:149–164.
- Eriksson, P. S., Perfilieva, E., Bjork-Erikson, T., Alborn, A., Norborg, C., Peterson, D. A. & Gage, F.H. (1998), Neurogenesis in the adult human hippocampus. *Nature Medicine*, 4:1313– 1317.
- Ernst, C., Olson, A., Pinel, J. Lam, R. & Christie, J. (2006), Antidepressant effects of exercise: Evidence for an adult neurogenesis hypothesis? *Journal of Psychiatry and Neuroscience*, 31:84 – 92.
- Exline, J., Jali, A. & Sanderson, W. (2000), Guilt, discord, and alienation; the role of religious strain in depression and suicidality. *Journal of Clinical Psychology*, 56:148–496.
- Martinsen, E. (1985), Comparing aerobic and non aerobic forms of exercise in the treatment of clinical depression: A randomized trial: A controlled trial. *Comprehensive Psychiatry*, 30:334–331.
- McCullough, M. & Larsen D. (1999), Religion and depression: A review of the literature. *Twin Research*, 2:126–136.
- McDonald, D. & Hogdon, J. (1991), *The Psychological Effects of Aerobic Fitness Training: Research and Theory*. New York: Springer.
- Musick, M. & Wilson J. (2003), Volunteering and depression: the role of psychological and social resources in different age groups. *Social Science & Medicine*, 56:259–269.
- Newsweek* (2007), Series on “Exercise and the Brain,” March 21, pp. 38–46.
- Nolen-Hoeksema, S. Morrow, J. & Fredrickson, B. (1993), Response styles and the duration of episodes of depressed mood. *Journal of Abnormal Psychology*, 102:20–28.
- O’Leary, J. (1997), A heterosexual male therapist’s journey of self-discovery: Wearing a strait-jacket in a gay men’s bereavement group. In: *Hope and Mortality*, ed. M. Blechner. Hillsdale, NJ: Analytic Press, pp. 209–221.
- Rajkowska, G. (2000), Postmortem studies in mood disorders indicate altered number of neurons and glial cells. *Biological Psychiatry*, 48:766–477.
- Ratey, J. (2008), *Spark: The Revolutionary New Science of the Brain*. New York: Little, Brown.
- Rugulies, R. (2002), Depression as a predictor for coronary heart disease: a review and meta-analysis. *American Journal of Preventive Medicine*, 23:5–61.
- Rutan, J., Stone, W. & Shay, J. (2007), *Psychodynamic Group Therapy*. New York: Guilford Press.
- Salmon, P. (2001), Effects of physical exercise on anxiety, depression, and sensitivity to stress. *Clinical Psychology Review*, 21:33–61.

- Seligman, M. (1972), Learned helplessness. *Annual Review of Medicine*, 23:407–412.
- Sheline, Y., Sanghavi, M., Mintun, M. & Gado, M. (1999), Depression duration but not age predicts hippocampal volume loss in medically healthy women with recurrent major depression. *Journal of Neuroscience*, 19:5034–5043.
- Sheffield, A., Wallace, M. & Klein, R. (1998), *How you can survive when they're depressed: living and coping with depression fallout*. New York: Random House.
- Solomon, A. (2001), *The Noonday Demon: An Atlas of Depression*. New York: Scribner.
- Wallace J., Schneider, T. & McGuffin P.(2002), Genetics of depression. In: *Handbook of Depression*, ed. I. Gotlib & C. Hammen. New York: Guilford Press, pp. 169–91.
- Yalom, I. & Leszcz, M. (2005), *Theory and Practice of Group Psychotherapy*. New York: Basic Books.
- Yunqing, L. & Ferraro, K. (2005), Volunteering and depression in later life: Social benefit or selection process. *Journal of Health and Social Behavior*, 46:68–84.

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