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Overview



We have all been sad. We have lost loves, dreams, pride, hopes, faith and on and on. Even periods of serious depression, like Abe Lincoln's, are not rare events. About 15% of us have been so depressed that it would have been wise to seek professional help (Wilcoxon, Schrader, & Nelson, 1976). But only one third of depressed people seek treatment (and they wait an average of 258 days to do so). Nevertheless, one third of all people seeing a psychiatrist are depressed. Depression is the first or second most frequent reason why people are admitted to the psychiatric wards in general hospitals (NIMH, 1971). A Presidential Commission on Mental Health estimated that 1 out of 5 of us (about 1 in 10 for males and 1 in 4 for females), will suffer from depression sometime in our lives. That is 20% in an

affluent country--the happiest country on earth; what about the poor countries? Women are twice as likely as men to be depressed; men get upset over jobs, women over relationships; married people in "not very happy relationships" are more likely to be sad than unmarried and divorced people. We will discuss these statistics later.

Depression is not only fairly common, it can be very serious. Like Abe Lincoln as a young man, the misery can be so constant, so great, and seem so seemingly endless that one wants to die--to escape the pain. In the U.S. one person every minute attempts suicide; one person every 24 minutes succeeds. There are more suicides than murders. Even among teenagers, it is third only to accidents and homicides. Almost 500,000 teenagers attempt suicide each year, not counting suicides disguised as "accidents" (McCoy, 1982). Suicide is so sad because it is a *permanent*, desperate solution to a *temporary* problem. What a loss to the world if Lincoln had killed himself. What a blow to each family in which an unnecessary death occurs.

My interest here is not so much with serious, disabling or suicidal depression, usually called Clinical or Major Depression. Indeed, if sadness is disrupting your work and schooling--and you are thinking of ending it all--seek professional help immediately; you need more than self-help; run no risk with your life. This "common cold of mental disorders" hospitalizes 250,000 a year, the most extreme cases. The "common cold" slows down many more of us and makes us gloomy. This chapter focuses on these less serious forms of depression: sadness, disappointment, loneliness, self-criticism, low self-concepts, guilt, shame, boredom, tiredness, lack of interests, lack of meaning in life, etc. Most of us are or will be somewhat depressed or disappointed and could use self-help. Overall, depression costs the country more in treatment and lost work than heart disease.

Are some people just naturally happy?

It sometimes seems like it. Were they just born with the hard wiring that makes them happy, cheerful, active, social, and optimistic? Maybe. It might have been an inherited family trait but happiness happens in other ways apparently. For instance, in many cases happy people are different from anyone else in the family; indeed, some had an unpleasant, neglectful, abusive family which they had trouble understanding but learned to tolerate. We don't know all the ways to become happy yet. Some chronically happy people are referred to by some doctors as having hyperthymia, similar to but the opposite of dysthymia (chronic, mild depression). See [Richard Freiman's 2002 article in the New York Times](http://query.nytimes.com/gst/fullpage.html?sec=health&res=940DE3D8143FF932A05751C1A9649C8B63) (<http://query.nytimes.com/gst/fullpage.html?sec=health&res=940DE3D8143FF932A05751C1A9649C8B63>).

Maybe some people just have more serotonin in their brains. Well, that sounds simple but it appears more complex than that because antidepressants increase serotonin within days but it takes weeks to reduce the depression. Research has also shown that giving an

antidepressant, such as Paxil, to normal people, who are not depressed, does *not* increase their happiness (it did reportedly reduce their anger slightly and increase their sociability). In addition, it is common knowledge that certain illegal drugs, such as Cocaine and Ecstasy, quickly produce euphoria (these drugs, like Paxil, presumably do this by increasing serotonin and dopamine), but the positive emotions soon fade and then depression and/or apathy rapidly increases.

If you have a cheery disposition, count your blessings. Let's look more closely at our limited knowledge about happiness.

There is a long-running controversy about the cause of depression (which means no one knows): some say our personal history or experiences (psychology) cause depression, others say brain chemistry causes depression. Both psychology and drugs relieve depression in some cases, so the treatment doesn't clarify the causes. My guess is that psychological factors play a role in almost all depressions and physiological (chemical) factors are significant causal factors in some depressions, especially the very severe cases.

Like several other human disorders, there is evidence that unhappiness runs in some families. Studies estimate that 15% to 40% of the risk of major depression results from genetic factors. Your genes may have predisposed you to be at a certain point on the happiness-depression scale, just as other genes may have predisposed you to be at a certain weight. But, most psychologists believe you can influence your weight and your mood; genes don't have perfect control. Yet, David Lykken and Auke Tellegen at the University of Minnesota suggest that we really don't have much control over happiness, pointing out that the thrill of a promotion or winning the lottery fades away in 3 to 6 months and you go back to your set point. Moreover, some of their studies have reported that happiness does not tend to be highly related, in our country, to education, income, success, type of job, or marital status. So, maybe the genes do seriously influence our happiness, but what are the possibilities of controlling our sadness?

I don't doubt that genes have some influence over your level of happiness. But, I also believe (hope?) that ways of seeking joy, being optimistic, tolerating losses, etc. are learnable skills. Some experts argue that your happiness is more under *your* control than your depression is. Interesting possibility but I don't think we know that much about mood control yet. In the case of both happiness and sadness, self-control will take wisdom, planning, and effort. You surely have to *pursue* happiness; it takes mindfulness and skills or knowledge.

What this chapter offers

In this chapter, after briefly discussing happiness, we will first consider the signs of depression: How do we recognize it? Of course, each of us feels and acts differently when depressed. There are many

ways to become depressed; thus, we will consider several explanations of sadness (see index above).

Since sadness may occur in many circumstances and arise via several psychological processes, we will also consider how depression develops in several common situations: during death or loss of a loved one, when alone, when feeling low self-esteem, when pessimistic, when having suicidal thoughts, when experiencing guilt and shame, when feeling bored, tired, or without interests, and when there are no obvious causes. Each depressive situation and each psychological dynamic may require its own unique solution.

After gaining some understanding of depression, self-help approaches will be discussed by levels:

1. Behavior--increase pleasant activities, more rest and exercise, thought stopping and reduction of worries, atoning for wrongdoing, and others,
2. Emotions--desensitization of sadness to specific situations and memories, venting anger and sadness, elation or relaxation training, etc.,
3. Skills--social skills training, decision-making, and self-control training to reduce helplessness,
4. Cognition--more optimistic perceptions and attributions, challenging depressing irrational ideas, a more positive self-concept, more acceptance and tolerance, decide on values and meaning, and
5. Unconscious factors--learn to recognize repressed feelings and urges, understand sources of guilt, and read about depression.

At the end of the chapter, you should be able to select the techniques that seem most likely to reduce your sadness. Then, following the steps outlined in chapter 2, you should be able to get in control of these kinds of feelings. In general, self-confidence, an easy-going disposition, and family support lead to a better recovery from depression.

History and Gender Factors in Depression

What experiences precede depression?

Does an unhappy adult have a history? You'd think so. Some researchers say there is not a strong relationship between how happy you were as a child or an adolescent and how happy you are as an adult. Yet, keeping in mind that happiness and depression are independent, Harrington (1990) followed up 80 children and adolescents hospitalized for serious depression and found 60% became depressed again before they were 30. Several childhood experiences have been related to adult depression: (1) feeling guilty as a child (1/3 did) and (2) a strained relationship with the same-sexed parent, especially if a divorce is involved, (3) a mother depressed enough that she needs help caring for the children, and (4) dominant, over-

protective parents using poor child-rearing practices, especially if fathers gave poor child care.

A large study of depressed adolescents (Kandel & Davies, 1982) found these factors were sometimes involved: (1) low self-esteem, (2) "acting out" anti-social behavior, (3) over-involvement with peer group and little with parents, (4) over-involvement with parents and little with peers, (5) authoritarian parents or "do-what-you-want" parents, and (6) depressed parents. Adolescents, in general, are happier if they have some pleasant involvement with peers and with parents who are basically democratic and happy.

Coryell, Endicott, & Keller (1992) followed adults who had never been diagnosed as mentally ill. Within 6 years, 12% developed major depression. Younger persons (under 40) were three times more likely to get depressed than were older people (yet, suicide goes up with age). Going through a divorce doubles the chances of getting depressed, especially for women. Women are diagnosed as depressed twice as often as men. Higher education increases the risk for women (not true in all studies) and decreases the risk for men. Women living on farms are prone to depression. There are other gender differences.

Gender discrimination in depression

In adulthood, some studies have found that depression is most likely to occur in unmarried women who are poor and have little education. They are disadvantaged and have little control over their lives so depression is not surprising.

Why are women more depressed than men? There are several possibilities why 25% of women will be depressed sometime in their lives, but only 10% to 15% of men. (Incidentally, 37% of women psychologists will be depressed, so knowing about academic psychology apparently doesn't help.) First of all, women are taught to conform, to serve, and to please others in a society that truly values and rewards self-serving individualism (if you aren't valued for doing what you think is right, you suffer a loss). Within this context, about 50% of women are physically or sexually abused before age 21, another 25+% are abused or coerced in later relationships, and 70% are sexually harassed. 75% of all people in poverty are women with children. Being a victim is, of course, depressing.

Also, an amazing thing happens at puberty. Before developing sexually, boys are more likely to be depressed than girls, but afterwards girls become twice as likely to be depressed and boys turn to delinquency. Not all girls get depressed, however. Susan Gore at University of Massachusetts reports that the adolescent girls who get depressed tend to become over-concerned and over-involved emotionally with their mothers' problems in a stressful home. Boys do not show this sensitivity to and involvement in family problems. (For one thing, depressed mothers interact less emotionally with sons than daughters.) Moreover, research by Joan Girgus at Princeton suggests

that it is body image ("I'm too fat" or "too flat"), not life events, sex roles, or social popularity, that causes the depression in teenage girls (while boys saw their adding weight as "adding muscle").

Nolen-Hoeksena and Girgus (1994) suggest that girls have certain personality traits that interact with the stresses of being a teenaged girl that produce depression and lower self-esteem. The personality traits are thought to be emotional dependence on relationships, less assertiveness, and passivity (or an inclination to worry about a problem situation rather than do something about it quickly and decisively, as a boy might do). Thus, maturing young girls may get distressed *when* interacting with desirable but sexually aggressive (scary?) young males, *when* they dislike or don't know how to handle their own bodily changes (breasts, pimples, over or under-weight, no butt, etc., etc.), *when* sexually teased, used, or abused, *when* their social activities are restricted more than boys, *when* peers, culture, and parents start to emphasize attractiveness, sexiness, and friendships more than intelligence, genuine caring, and preparing for one's life work. We are gradually finding more and more childhood factors related to teenage depression.

A frequently cited statistic is that women are twice as likely to become depressed as men (and two or three times more likely than men to *attempt* suicide). It is an interesting coincidence that women are also about twice as likely as men to "over-think," which is ruminating mostly about unhappy events in the past (in contrast to worry which often focuses on bad things that might happen in the future). This could be another bit of evidence that negative thoughts produce negative emotions (although the above observation that females dramatically increase their negative thoughts at the time of puberty also suggests something else may be an underlying cause of both negative thoughts and depressed feelings).

Susan Nolen-Hoeksema (2003) has written a book based on her research about "over-thinking" in women, *Women who think too much: How to break free of overthinking and reclaim your life*. The result of over-thinking is that women (and men!) work themselves into a complex, confused emotional state where conclusions and solutions become difficult, if not impossible. Women may be more prone to over-think because they are sensitive to others and are often expected to solve personal conflicts without offending anyone. Nolen-Hoeksema found three types of over-thinking: 1. Rant and Rave—we believe someone has done us wrong and become self-righteous and plan revenge. 2. Psycho-analyzing—we replay an offending event over and over in an effort to understand why people did what they did and why we are emotionally responding as we are. We construct a huge psychological problem which seems to defy any treatment plan. 3. Chaotic—one upsetting thought (emotion) triggers another in a chain reaction, often not directly connected at all with the current event, so that eventually there is a huge conglomeration of entangled emotional experiences in one's mind but few constructive conclusions.

Nolen-Hoeksema believes the over-thinking tendencies can be countered by 1. being mindful of the onset of the process, then immediately switch to another activity, perhaps take a walk, call a friend, read a book, plan a nice weekend, etc. Somehow stop the mental buildup of emotions. 2. If you are mentally absorbed with a problem, DO SOMETHING that might clarify the situation, lessen the stress, or point a way out, don't just think about being upset. For instance, if you are dwelling on the impact of weight on your looks, health, and love life, reduce the thinking and increase the serious long-term problem-solving, such as plan and buy the food for healthy meals, firmly commit yourself to daily exercises (no excuses!), get your doctor's advice, read references that may help you understand the emotional needs to over-eat.

When a woman gets married, she often has more roles to manage than a man: work, partner, mother, social relations, friend, budget balancer, etc. She may identify with her mother rather than her father; her mother was more likely to be dominated, anxious, and depressed. Therefore, she is more likely to be passive-dependent, pessimistic, doubtful of her ability to manage her own life well, and depressed. Since we are a more mobile society, women may also have more sadness when leaving relatives, friends, etc. The spouse of a depressed person is more likely to become angry and blaming. Finally, women must give birth, which is supposed to be a glorious experience but is scary and painful, plus 50% have PMS, 50%-80% have postpartum depression, and 30% have surgical menopause, according to Ellen McGrath of the APA Women and Depression Task Force. A victim of discrimination, such as getting less attention in school and less pay for the same work, is likely to be mad and/or sad (McGrath, Keita, Strickland, and Russo, 1990).

The Signs of Depression

Depression is a loss of an important life goal without anyone to blame. Such a loss affects our behavior, our moods or subjective feelings, our skills, our attitudes or motivations, and our physical functioning and health. Several writers (Levitt & Lubin, 1975; Beck, 1973; Lewinsohn, 1975) have summarized the signs of more severe depression:

- **Behavioral excesses** --complaints about money, job, housing, noise, poor memory, confusion, loneliness, lack of care and love... acting out (adolescents), running away from home, rebellious, aggressive... obsessed with guilt and concern about doing wrong, about being irresponsible, about the welfare of others, and about "I can't make up my mind anymore"... crying... suicidal threats or attempts.
- **Behavioral deficits** --socially withdrawn, doesn't talk, indecisive, can't work regularly, difficulty communicating, slower speech and gait... loss of appetite, weight change, stays in bed... less sexual activity, poor personal grooming, and doing less for fun.

- **Emotional reactions** --feels sad, feels empty or lacks feelings of all kinds, tired ("everything is an effort")... nervous or restless, angry and grouchy (adolescents), irritable, overreacts to criticism... bored, apathetic, "nothing is enjoyable," feels socially abandoned and/or has less interest in relationships, sex, food, drink, music, current events, etc.
- **Lack of skills** --poor social skills, frequently whiny or boring, critical, lack of humor... indecisive, poor planning for future and unable to see "solutions."
- **Attitudes and motivation** --low self-concept, lack of self-confidence and motivation, pessimistic or hopeless, feels helpless or like a failure, expects the worst... self-critical, guilt, self-blaming, "People would hate me if they knew me"... suicidal thoughts, "I wish I had never been born."
- **Physical symptoms** --difficulty sleeping or sleeping excessively, awaking early... hyperactivity or sluggishness, diurnal moods (worse in the morning)... low sex drive, loss of appetite, weight loss or gain, indigestion, constipation, headaches, dizziness, pain, and other somatic problems or complaints.

If you are trying to determine if you are depressed, there are several things to keep in mind. First, Levitt and Lubin (1975) found 54 symptoms of depression. Obviously, no one has all these signs. These are problems that tend to be associated with being sad. Yet, a depressed person may have only one, two or three of these signs. There are three important types of depression: (1) *major depression* is serious enough to interfere with work and social life. Sometimes it is called endogenous depression because it seems to come from within and not a reaction to external events. It affects sleep, appetite, energy level, self-esteem, and thoughts of suicide often occur. (2) *Situational or reactional depression* is more common and sometimes more clearly a reaction to a loss in life. It is a serious "downer" or "blue spell" but usually not disabling. Psychiatrists call it *dysthymia* or chronic sadness if the blue mood lasts for two years or more. After a while, many do not know why they are down in the dumps. (3) *Bipolar disorder* or manic-depression involves cycles of sadness and mania (too happy, irritable, insomnia, grandiosity, hyperactive and talkative, poor judgment, fast and unreasonable thoughts). The bipolar types are just as likely to be men as women, more extroverted, and more likely to have relatives with depression. Unipolar types, (1) and (2), are twice as likely to be women. Bipolar and unipolar respond to medication differently; thus, they appear to be different disorders.

Secondly, the symptoms found and the judgment of how serious the symptoms are, vary according to who is making the diagnosis and how it is being made. For instance, the judgment that a particular person is depressed might be made by a therapist, family doctor, friend, spouse, psychological tester, or by self-evaluation. There is often *little agreement* among these judges; for instance, MD's *miss the diagnosis* in 7 of 10 depressed men and 5 of 10 depressed women. On the other hand, mental health workers over diagnose depression by 15% to 20%. Sometimes even the psychological tests don't agree with

each other. This is a serious problem for diagnosis and for treatment as well as for research. Don't be surprised if you get conflicting opinions.

In most instances, the person knows when he/she is unhappy. If you feel sad, that's it; you are the final authority. However, the victim doesn't always recognize his/her own depression (so the "final authority," i.e. you, may need to re-think the situation). Physical complaints sometimes hide depression.

Consider this: Gillette and Hornbeck (1973) reported a case of a 54-year-old housewife who went to an emergency room with a painful earache. She had seen three other MD's in recent weeks. None could find the cause. Again, nothing could be found wrong with her ear and she was sent home with pills (aspirin). Three days later she jumped off a bridge. She hadn't opened the aspirin bottle. Accurate diagnosis of depression is a problem. Depressed people frequently have physical complaints; ill people are often depressed. Certainly some don't tell their doctor even if they are aware of sadness. This concealed gloom is called masked or smiling depression.

Even when depression is clearly expressed, physicians often ignore it. A follow up of 25 people who committed suicide showed that 23 had visited a physician within the last few weeks--and, according to the doctors' own notes, 80% "showed clear evidence of depression." Yet, few were actually diagnosed as depressed and *none* were given anti-depressant medication! Physicians might do better if they used a brief, simple questionnaire. But don't expect your doctor to read your mind or even to ask about depression, you must be very clear about your feelings and your needs. It is crucial that doctors know and DO SOMETHING about your emotional state. And, if your doctor or anyone thinks you have a psychological problem, please listen carefully.

Thirdly, the diagnostic picture is often complex, i.e. a person isn't just depressed and that's all. On the negative side, many depressed people are also anxious, and they may have personality disorders, such as cyclothymic, borderline, schizoid, dramatic, passive-aggressive, avoidant, and so on. On the positive side, perhaps more than half of well known poets, playwrights, and novelists have mood disorders, unfortunately several have severe manic-depression as well as great creativity and sensitivity.

Fourthly, it is tempting to believe there are two separate, unrelated processes going on in depression, one biological-chemical and one psychological, each causing a different kind of sadness. Several experts (Free & Oei, 1989) say the evidence for this basic assumption is scant, because the organic and the cognitive components seem to be very interrelated.

Even the professionals often have difficulty detecting depression, so recognize that self-diagnosis may be hard. When in doubt, get help. In its serious form, depression is a dangerous illness. Even in its

milder forms, it is a miserable condition. This is a sickness that can not be simply "willed" away.

Happiness

What is meant by happiness?

Considering that happiness is "the most important thing in life," according to about half of Americans, science doesn't know a lot about it. We don't even have an agreed upon definition for it. Is it having lots of fun and pleasure? Is it being good looking, popular, and intelligent? Is it feeling very lucky and gratified? Is it living a virtuous and intellectual life, as Aristotle said? Is it having a positive attitude and simply believing you are happy? Is it having lots of money? Is it when things are going well, you have gotten more than you expected, and you are having far more pleasant feelings than negative feelings? Experts often say happiness is more than just having a good time or lots of things, it involves a lasting sense of well-being, it is having a fulfilling, meaningful, pleasurable life (Meyers, 1992).

Perhaps the definition of happiness is vague because each person's happiness is contingent on achieving his/her own unique life goals, which often involve secret hopes and dreams. This may also explain why other people are hard to understand--we just don't know how they are trying to achieve happiness. Once we understand what "makes them happy," we may have significant new insights into the other person's psyche. In our culture, we often seek happiness by removing all stress, sadness, and irritations. Of course, that is impossible over a long period of time.

There are several measures of depression, self-esteem, internal control, optimism, etc. but few ways to measure happiness. Perhaps because we all think we know what happiness is. Nevertheless, it would encourage science if we had an objective, reliable measure of happiness. Two British psychologists, Pete Cohen and Carol Rothwell, interviewed 1000 people and came up with a formula for measuring happiness:

$$\text{Happiness} = P + (5 \times E) + (3 \times H)$$

where P is a single self-rating from 1 to 10 of several Personal characteristics, including being outgoing, energetic, open to change, having positive expectations, and feeling in control,

E is a single 1-10 rating of health, financial situation, feeling safe, having choices, and friendships, and

H is a single 1-10 rating considering self-esteem, ambitions, support system, sense of purpose, and ability to get into "flow."

This formula produces a number (9 to 100) which defines a person's level of happiness but the total number is based entirely on self-ratings. Self-ratings often have little agreement with ratings by therapists, family, or friends or with objective and physiological measures. However, we usually accept a person's opinion of how happy he/she is. Also, on the positive side, the formula clarifies the several factors that these investigators believe contribute to happiness, much in the same way Seligman (2002) does later in this section.

Many more people say they are happy than say they are unhappy, maybe because it is more socially acceptable to be positive. It is also quite possible that more pleasant than unpleasant events actually happen. Most of us consciously try to find or arrange positive events. In addition, there seems to be a natural tendency (except in depressed persons) in our memory system to forget unhappy events faster than happy events (Walker, Skowronski & Thompson, 2003). Many cognitive researchers don't believe, as Freud did, that traumatic events are forgotten as a defense mechanism; they think unpleasant memories are just remembered less negatively because that feels better. So, from the cognitive viewpoint, the greater fading of unhappy memories is seen as healthy coping.

Another way to think about it is that being happy in a wealthy materialistic society, like ours, involves putting your head in the sand...and forgetting that a billion people go to bed hungry every night...and need medical care...and need an education...and are unhappy. So, some people would say happiness is a sickness or, at least, gross denial. No wonder we don't know how to measure it or change it.

Another theory that would seem to discourage trying to change is the notion of individuals having a happiness set point (Lucas, Clark & Diener, 2003), much like a weight set point. We will see over and over in this chapter that both wonderful and awful changes in life circumstances can make us delighted or really down for a while, but in a couple of years our level of happiness is back to our old set point. Such set-points may also influence how much our feelings change in other situations. For instance, stable happy people may not react with a big surge of happiness when they get married even if it is a wonderful new relationship...but, in contrast, the usually happy people might experience a huge increase in unhappiness if faced with a divorce. Likewise, an unhappy, lonely person may be quite happy getting into a good marriage but not be very bothered by a divorce since their life-long set point is low. At least, that is a theory. And,

there is a related theory that some of us become obsessed with or addicted to unhappiness (Pieper & Pieper, 2003).

All these theories have to take into account that Buddhists, practicing meditation, have been shown to be happier and less shocked, surprised, distressed and angry than other people (Dr. Paul Ekman, *New Scientist magazine*, 2003). There are many other mysteries—Latin Americans are much happier than Asians; Scandinavians have both a high rate of happiness and suicide; women are as happy as men but twice as likely to feel depressed. We need scientific studies to understand exactly how cultures, attitudes, belief systems or whatever produce these different levels of happiness.

Indeed, as noted in the introduction, good luck and bad luck don't influence happiness for long. For instance, big lottery winners after a few months are no more happy than the average person! Quadriplegics are no less happy than the average person! Yet, 70% to 80% of Americans are happy and 84% take pride in their work. People are considerably less happy in poorer countries and only 35% to 40% of Europeans and Japanese take pride in their work (while making the best cars, computers, TV, etc.). While America is among the happier countries, our level of happiness has not increased as our country's level of real income has grown... but our problems, such as violent crime, divorce, and depression, have soared. Also, in spite of Americans' claiming to be generally happy, 33% said they worried constantly, 40% had often felt lonely, and 28% felt worthless during the last six months (Shaver & Freeman, 1976). Over 50% said their happiness changed daily or every few days. Married couples in their 20's are the happiest; divorced women with children and unmarried males are among the more unhappy. As we will see, good interpersonal relations are crucial to many people's happiness.

Clearly, certain events, such as a party, are pleasurable to most people, but certain people, namely the depressed, get little pleasure out of many such events. You have probably had a similar experience: you have to be in the right "mood" to enjoy certain activities. So, is happiness the mood or the activity? Probably both. A big argument between philosophies is whether happiness is gained by satisfying our desires (hedonism) or by getting rid of our desires? Maybe both, again. Also, does happiness occur mostly *during* the striving for worthy goals or *after* having achieved our goals and desires? It seems that a windfall or achievement makes us happy for a short while, but we adapt to the bigger house, boat, car, income, etc., and soon start to lust for a still bigger one.

How do we become happy?

There seems to be so many ways to be happy and, as we will see, unhappy. Why do we know so little about this very important topic? Why haven't humans investigated it more seriously? I suspect it is because a lot of us erroneously believe we have little control over our happiness, so why bother studying it... and those of us who believe we

are in control of our happiness already think we know all we need to know about it. Sad. Surely humans will in the coming decades learn to influence their own happiness to a great extent. The secret, I currently believe, is finding hard, meaningful, demanding-but-fun ways to achieve your highest values. See chapter 3. For me, a serious cultural problem may be that 75% of college students say "becoming very well off financially" is their highest aspiration--above "raising a family" and "helping others." Only 40% said that in 1970. Note that criminals, cons, deceptive business people, and drug dealers are also striving to become well off financially.

In our culture, it is commonly believed that happiness happens when you become rich, powerful, or popular. Recent research (Sheldon, Elliot, Kim & Kasser, 2001) suggests those beliefs are wrong. Their study found that meeting other needs bring more happiness. What were the most happiness-related needs? Autonomy (self-direction, being in charge of your own activities), competence (feeling and being able and effective), relatedness (having meaningful, satisfying, caring relationships) and self-esteem (accepting and feeling OK about one's self). Other research findings have also found that happiness is related to self-esteem, loving relationships, extroversion, good health, satisfying and challenging work, having exciting goals and interests, status and power (education and money), a sense of control over our good fortune and an optimistic outlook, being helpful to others, and making an effort to do new and fun things (Diener, Sandvik, & Pavot, 1990). Thus, there seems to be some research agreement about what makes us happy, but the young still yearn for extraordinary stardom and the older folks want to win the 1-in-30-million lottery. Being able, caring, and self-directed, so that we accomplish ordinary goals and have a sense of adequate mastery of common lives and relationships, has the potential of making us happy, but many of us seem to invest our hope in some highly improbable goal. The result sometimes is that we spend our lives wishing for the impossible while we merely get by at work, our relationships deteriorate, and we can't even learn to lose weight.

Waterman (1993) says there are two aspects to happiness. One is "*personal expression*" and the other is "*hedonic enjoyment*." Personal expression is self-actualization, i.e. using your talents, taking on meaningful and challenging projects, working hard and guided by your values, and feeling confident and satisfied. Hedonic enjoyment is having fun, i.e. satisfying your needs, feeling relaxed, excited, happy, content, etc., and being able to forget your personal problems. What is very surprising and perhaps quite important was Waterman's finding that *the two types of happiness are highly correlated*, i.e. happy people tend to achieve and have fun while unhappy people get neither. Vigorous, productive self-actualizing doesn't eliminate fun, it seems to enhance it.

Ed Diener at the University of Illinois says that life is judged happy if we have more positive experiences (an enjoyable job, loving spouse, a hobby, etc.) than negative ones on a day to day basis and, in

addition, can occasionally manage to have an intensely positive experience, such as a new child, a fantastic vacation, public recognition for an achievement, etc. The frequency of positive experiences is more important, Diener says, than the intensity of occasional positive events.

The Interaction of Happiness and Depression

It is commonly thought that happiness is the positive end of the depression scale. Of course, in the extremes, great happiness and deep depression are mutually exclusive; you can hardly be in the depths of suicidal depression and be considered happy at the same time. But in the less extreme ranges, happiness and depression appear to be rather independent of each other. It is very interesting that psychologists consistently find women in general are *more depressed* than men, but psychological tests also show men and women are *equally happy*. This clearly shows that *happiness is not just the opposite of depression* (Myers, 1992). This also fits with common sense about happiness. That is, people know they can go out and have a good time at a party, then come home to be lonely and miserable again. Another example: you can handle some situation that is causing you to be very unhappy, but that accomplishment may not produce much happiness, just relief from the pain. You can be unhappy about some things and happy about others at the same time, much like you can both love and hate a person at the same time (Swanbrow, 1989; Diener, Sandvik, & Pavot, 1990). In contrast, you can't be both relaxed and anxious at the same time.

We are learning more about happiness. One interesting point is that happy people tend to be decisive, healthy, creative, motivated, social, trusting, and caring, compared to unhappy people. Another is that they feel "in control" and/or have a sense of well being. As you might expect, happy people have more faith in a "higher power" than unhappy people. Among atheists and non-religious, only about 15%-30% claim to be "very happy." Among religious folks, 25% to 40% say they are "very happy." A religion helps us handle great losses (probably due to the concept of eternal life), but religious people sometimes feel less in personal control (Myers, 1992).



Religion becomes self-therapy.
-David Myers

We must select the illusion which appeals to our temperament and embrace it with passion, if we want to be happy.
-Cyril Connolly



In some cases, however, religion reinforces feelings of guilt and the person becomes a martyr who feels he/she deserves punishment or needs to endure unhappiness. They may feel so unworthy that life only has meaning if they suffer great hardship and pain. Others think they do not deserve to feel good; thus, if life is going well for them, they quickly find a problem to feel badly about (see later discussion of shame and guilt). Such people focus on the seriousness of life. Overall, however, to most people religion probably gives more satisfaction than grief.

The important point for the self-helper is that happiness and depression are two somewhat independent dimensions--you need to *work on both decreasing depression and increasing happiness*, if unhappiness is a problem for you. Yet, it seems that trying too hard to be super happy is like trying to be someone you aren't; that too may be a bad idea. Instead, "To thine own self be true" while making efforts to be happy: seek demanding, challenging work; exercise in a fun way; do several pleasurable things every day and show your happiness; nourish close relationships, and be good to others.

Finally, a Buddhist friend would tell you to learn to accept the good *and* the bad in life--accept and relish all of life (see irrational ideas and determinism in chapter 14). This means recognizing the 6-year-old inside each of us who wants the most attention and the biggest piece of cake. This self-centered child part sees bad events as a personal insult that shouldn't be happening, rather than as a naturally occurring event. We must come to see that our I-don't-like-it attitudes create our unhappiness, not the actual event. Why should getting just an average piece of cake make us upset when many people are literally starving and others are killing themselves by over-eating? Should everything happen because we want it to? Of course not. Happiness is based on the ability to take all the insults of life, without responding with tension, sadness, or rage. Whatever has happened was psychologically lawful. Accept it... and try to improve the future for yourself and others.

Martin Seligman's Thesis on Happiness

Psychology Finally Attends to Positive Feelings and Traits

Martin Seligman (2002) was once best known for his research of learned helplessness, an important aspect of hopelessness and unhappiness. He became interested in Cognitive-Behavioral Therapy in which the patient is helped to look for evidence for and against his/her own beliefs. His focus shifted to optimism. He has in recent years become a leader of a new "Positive Psychology" movement which underscores the importance of positive emotions and traits, especially optimistic thinking, such as "I can manage."

Positive Psychology points out that applied psychology for over 50 years has focused mainly on psychopathology--disorders people will readily pay to get rid of, such as depression, fears, anger, bad habits,

psychoses, marital problems, etc. We have learned to be somewhat successful treaters in many of these troublesome areas (Seligman, 1995). All this attention was given to suffering, sickness, and treatment, and while that was commendable, it left other important aspects of life neglected, e.g., finding really meaningful lifestyles, being truly happy and satisfied with life, feeling confident and optimistic, and behaving generously, altruistically and nobly, and so on. These are important, exciting new directions for applied psychology.

For decades, psychology "bought" the Freudian notion that the major driving forces in humans were bad motives--greed, lust, aggression, etc.--and originated in our basic human nature and/or from bad parenting. Even being good and altruistic is often believed to come from our evil core, as when generous, helpful people are thought to be *compensating* for their immoral selfish urges, faults, fears, and sick needs. It seems more superficial and Pollyannaish when we explain some human behavior as being caused by good parenting, genuine concern for others, feelings of satisfaction and joy, a sense of responsibility, a devotion to high morals, and so on. Such positive explanations often give rise to the question, "Don't put me on, what is really going on?"

If psychologists had emphasized positive traits more, they surely would have conceptualized the causes of behavior in more positive terms. If they had focused more on positive human characteristics, they probably would have concentrated more on psychoeducational approaches, such as character development, developing a philosophy of life, learning self-control and self-help, exploring how to develop good families, friendships, work relationships, humanistic educational systems, peaceful caring nations, and so on. Seligman and other positive psychologists think enhancing our positive traits and emotions is the key to further improving human lives. Positive Psychology goes far beyond treating mental illness, in fact doesn't have much to do with it. Positive emotions are powerful influences; they increase our social, mental, and health benefits; they help prevent problems.

Not just Seligman but a productive group of psychologists are engaging in research and theory-development about positive emotions. See the *Handbook of Positive Psychology* by C. R. Snyder & Lopez, S. J. (2003). Barbara Fredrickson (2003) at the University of Michigan has published a series of studies and a theory, called the "broaden-and-build" model, which proposes that positive emotions and attitudes broaden our thinking about possible solutions to problems. If we are open to new ideas, we think better. Over time this broader perspective enables us to build broadly our coping skills and confidence. Thus, positive and optimistic societies become more innovative, resilient, socially adjusted, and healthy. Seligman gives Fredrickson credit for opening his mind to the general importance of positive psychology. Psychology is currently generating considerable research that empirically documents the value of positive thoughts and emotions, e.g., Emmons & McCullough (2003) have shown that

counting our blessings (being grateful) has positive impact on several aspects of our mood, adjustment, and physical symptoms.

Forces Affecting Happiness and Depression

Current research suggests a tendency towards depression is inborn so that each of us probably has a set point for depression and on a different dimension for happiness. Studies of twins and adopted children support the inheritance notion. Of course, in spite of any set point, radical changes in our lives can change our feelings. Someone important to us dies and we are saddened for months, but eventually we usually come back to our set point. Winning a multi-million dollar lottery has drastic impact on our emotions but only for a year or so, then we go back to our usual mood. Paraplegics return to their pre-accident level of happiness after a year or two. Sure, there are some terrible experiences so traumatic that some people can't ever recover, like the death of a child or a brutal assault. In the opposite direction, a lonely person, who finds someone who really loves him/her, may be in high spirits for the rest of his/her life.

Seligman doesn't let us forget our ever-present genetic guidance system and estimates the available data suggests that one's general level of happiness is about 50% inherited—he believes even being of good cheer is about half determined by the genes. Okay, but the genes are, thus far, beyond our control. We have to just make the most of what we were given at birth. We also have only limited control over our natural body chemistry, such as serotonin, that affects our happiness. Most people believe that life circumstances have a powerful influence over their happiness (“if I get rich, I will be happy”) but the research findings, as we have seen, suggest that our circumstances are the source of only 10-15% of our happiness. In short, our genes and our brain chemistry may be barriers to happiness...and our hopes that good fortune will bring us happiness via good circumstances may be illusions. To Seligman another approach to happiness has much more potential--he believes we have the ability to develop and use personal habits, attitudes, and traits that can increase our happiness. This is his general thesis and the basis of his self-help approach. Let's try to understand this.

Seligman, being an academic researcher, cites a great deal of research and presents it in an interesting way, but keep in mind that he is mostly discussing the "commonly used ways to gain happiness" that are currently available to the average person. In general, he doesn't invent new happiness-producing techniques. Remember, too, this is primitive science...just estimates of correlations between crude circumstances and happiness over large numbers of people. It is important to keep in mind, I think, that there are probably hundreds of unique ways for unique individuals to gain happiness. You don't have to be married and have children...or be educated, highly successful, and make big money...or be religious and get your hope through the promises of religion...some people can probably even be happy while

being self-centered and immoral. There are many ways you can carve your own niche of happiness in the world.

Given time, often involving life-long endeavors and goals, you can certainly have some influence over the circumstances of your life, in spite of the research cited above. Yet, we all know being born with below average academic ability or given parents who belittle learning or provided a poor K-12 education, it is very hard to become a physician, astronaut, professor, etc. Much of *Psychological Self-Help* deals with exactly how to make some of these changes in circumstances or the environment (see the chapter indices and use the search engine on the main page to find self-change methods). Keep in mind, however, that while your life circumstances usually only determine a small part of your total happiness, once a barrier is overcome and put behind you, such as poor education, self-doubts, or shyness and a lack of friends, it is no longer a barrier and your unhappy circumstances in the past may even become an asset.

Positive reactions and attitudes towards the past, the present, and the future may be more modifiable for most people than actual life circumstances. Let's review Seligman's (2002) work to learn more about this.

Seligman's Suggestions for Increasing Happiness

Note: the next several pages offer a detailed summary of *Authentic Happiness* and a critique. If you are into serious and long-term work on building happiness, you might be well advised to read and work through the book itself, rather than read my summary. Hopefully, my overview will put Seligman's suggestions into perspective, and then you can apply the more hopeful specific techniques from several sources.

His book, *Authentic Happiness*, begins by reviewing the benefits of being happy, much like the research I've just summarized. An optimistic, happy person has a better chance of being more productive, having more friends, a satisfying marriage, better health, and a longer life (of course, those end results contribute to one's happiness, so there is a chicken and the egg question here). Happy people are not the most realistic, e.g. they over-estimate their skills and the control they have in dealing with problems; they see themselves as above average in intelligence and social ability. Seeing yourself favorably, even if wrong, contributes to happiness, I suppose, but other research shows optimists are not happier and more successful than pessimists (Chang, 2000).

No one would deny that great contributions to the world have been made by very unhappy people. So, sad feelings may have some merit and contribute to doing good in many lives. Indeed, people with bipolar disorders often enjoy the "highs" on their hyperactive days. They are often more creative than us ordinary folks. Some therapists believe that chronically happy and overly joyful people might be prone

to become hypomanic (impulsive and overactive) if they “go over the edge.” Certainly, strong negative and strong positive feelings can both motivate us powerfully. Some historians and anthropologists believe that positive feelings helped our species evolve, just as fears and envy surely did. Given the choice, however, most of us as individuals would prefer a productive life without being depressed or manic. And no one would deny that many important contributions have been made by happy, enthusiastic, able, well adjusted people with lots of friends.

Which life circumstances change our happiness level and which don't?

Here is some important research we need to know:

Relationships--a close, lasting, caring love relationship is for many a wellspring of happiness. Having good friends also gives most people continuing pleasure, too. A quarrelsome relationship can be the cause of much lasting unhappiness. Being lonesome continues to be unpleasant year after year. Maintaining a loving partnership is one of the surest ways to happiness—40% of married people say they are “very happy” (that is a little higher than the usual estimates). Only 25% of unmarried, divorced, separated and widowed say they are “very happy.” Remember they have suffered a significant loss.

Religion--religious people tend to be a little happier and more satisfied with life. And why not, since they have a relationship with God, maybe a special sense of purpose, the promise of a wonderful life after death, and a facilitated social life? The more fundamentalist the religion, the more optimistic the believers tend to be, and the higher level of hope they tend to have.

Money—while, in general, people living in a wealthy, free country are clearly happier than people in a poor country, making a lot of money is usually an ineffective way to achieve happiness. In fact, once we get into a materialistic mode of acquiring “things,” the result is often less happiness, maybe even compulsiveness, competitiveness, boredom, or meaninglessness in the long haul.

Negative feelings--one might think that avoiding negative emotions and situations might make our lives happier, i.e., filled with more joy, but that is not necessarily true. Some people don't have many feelings, positive or negative. Other people have lots of negative feelings *and* lots of positive feelings. Indeed, women have about twice as much depression as men...and they have about twice as much joy. So, holding down or escaping unpleasant feelings might help a little to be happy but it isn't a sure-fire powerful tool.

Most other situations in life have relatively little to do with happiness. That includes age, health, degree of education, climate you live in, race, and gender. You can't change most of these things anyway. Thus, it is easy to see that gaining happiness by changing

your circumstances is a hard way to go. Only 25% or so of us achieve a really good, lasting, loving relationship (in spite of the 50% “very happy” ratings at any one time mentioned above). Perhaps only 10% or 15% of us worldwide can arrange to live in a wealthy democracy. Getting religion if you don’t have it is hard, it can’t be forced. Likewise, reducing negative feelings requires psychological skills and methods.

A little summary: According to Seligman the role of *circumstances* in happiness is quite limited: education, income, and climate don’t influence happiness very much; feeling healthy, avoiding trauma, and developing hope through religion only contribute moderately to happiness; however, important life conditions include achieving a good marriage and living in a wealthy democracy. OK, but what about other life circumstances, such as raising a healthy, happy family? Having a successful career one is very proud of? Living an altruistic life devoted to helping others? What about being the best mechanic or a loved teacher in your town for 50 years?

More promising routes to happiness

Seligman obviously doesn’t think “trying to change your circumstances” is the best way to become happy. Instead, developing new personality traits, different outlooks, and more positive attitudes offer more hope because they may be more under your voluntary control.

Starting from the great virtues identified by philosophers over the last 5000 years, such as wisdom, courage, love, justice, temperance and transcendence, Seligman tries to help each person discover their own unique strengths or virtues. He calls these individual traits your “signature strengths.” Much of his book focuses on teaching you to nurture your positive natural traits or virtues, so you can live “the good life” and experience authentic happiness in work, love, and child rearing. To his credit, he has also developed a Web site (<http://www.authentic happiness.org>) which supplements his book. The site offers rating scales which are automatically scored, explained, and stored in your personal test folder. The ratings measure and provide norms for several of your traits or characteristics, such as your Signature Strengths (listed later), happiness, positive and negative feelings, optimism, close relationships, and so on. If you decide to take Seligman’s book seriously, please also make use of these rating scales. Note: he openly states that he intends to use your test scores in his future research...I feel confident that he will hold your information in confidence and deal with your disclosures respectfully.

Seligman has a very different understanding of psychopathology than the Freudian psychodynamic psychotherapists who see childhood trauma as the usual cause of adult unhappiness and disorders. Seligman believes childhood experiences—abuse, neglect, divorce, parent’s death—are over-rated causes. Many current therapies reinforce people feeling victimized by the past; after treatment they feel imprisoned and embittered by mistreatment as a child. But the

new Positive Psychologists say childhood experiences just don't have that much impact on adult unhappiness, so the bad feelings don't need to be dug up in therapy. They prefer the Cognitive Therapy approach rather than uncovering the past in great depth. They admit, however, that if bad past experiences are remembered over and over, ruminated about, and expressed as terrible events, these thoughts could cause depression. The assumption is that awful experiences will fade away if they are out-of-mind and not re-lived. Therefore, the cognitive approach (see my chapters 5, 6 and 14) is different from many insight therapies (see my chapter 15). Remember—probably the majority of psychologists believe bad, traumatic childhood experiences often have a lasting impact, just as the good positive experiences recommended by Seligman might.

His next three chapters focus on developing healthy attitudes towards viewing and accepting your past, being optimistic about the future, and increasing your pleasures and gratifications in the present. His Web site (<http://www.authentichappiness.org>) starts you thinking about how you actually see the past by giving you three tests: Satisfaction with Life Scale, The Gratitude Survey, and a Transgression Motivation scale which measures your need for revenge. Your story of your life is really your cognitive explanation of your life. What if, as Seligman argues, childhood experiences have little to do with your adult life? What if the genes have much more powerful influence than a critical mother, a distant father, abuse, your parents' divorce, a death of a parent, etc.? The dwelling on childhood in therapy would be pretty much a waste of time! The Cognitive Therapy view is that every emotion is the result of our recent thoughts. Examples: a thought that we are going to mess things up causes anxiety and feelings of insecurity; the thought that someone is going to screw me over causes anger; the thought that my lover may be interested in someone else causes jealousy, resentment, and fear of loss. So, effective treatment involves changing your thinking about your past in the direction of appreciating good events in your past and understanding (with some forgiveness) the wrongs done to you. How can you do this?

Completing the Satisfaction with Life Scale and the Gratitude Survey on Seligman's Web site should get you started thinking more positively about the past. These additional exercises are recommended: Start keeping a daily diary in which you describe three to five things that happened to you that day that you appreciated. Your joy, happiness, and life satisfaction should increase because you are thinking more about good happenings. Another suggestion is to write up a one-page description of someone who has made an important contribution to your life. Arrange to take some time face to face with this person, express your gratitude, actually read your testimonial to them and give them a copy, and spend some time discussing the events, your feelings, and their feelings. The idea is to learn to appreciate and savor the good parts of your life.

This may be one of the weakest parts of Seligman's approach. The experiential and experimental bases for his therapeutic suggestions

are primarily brief classroom exercises, short experiments using students, or old humanistic exercises. It seems to me that this is a flimsy basis to suggest such brief experiences will change the life-long habits of being unappreciative and emphasizing the negative. Being more appreciative and grateful in a class assignment may be good beginnings but much longer efforts to change spread over many more areas of your life will be needed to permanently change your basic personality from negative or positive.

Likewise, negative thoughts, angry resentments, prejudice towards groups, thoughts blaming others, and the urge for revenge (he has another rating scale for that) can't be undone in a short while. Seligman, himself, enumerates several reasons we are reluctant to give up our bitter thoughts about the past. Moreover, he has repeatedly emphasized the power of genetic inheritance in influencing these powerful behavioral/emotional reactions and then seems to suggest in his book that these reactions can be overcome by briefly "re-writing your history," i.e., by reconsidering, forgetting, forgiving or suppressing your bad memories. He gives one example of how a psychologist (Worthington, 2002) forgave someone—a person who had killed his mother. It is a good example of understanding (by a professional specializing in forgiveness) forming the basis for forgiveness. I certainly believe the research findings that forgiveness training (done in the laboratory) leads many subjects to reporting less stress and anger later. However, it may be different in highly complex real life. Unlike a psychologist, such as Worthington, a critical, resentful, vindictive person has years of habits of thought to overcome and erase. In that case, becoming understanding and mellow is likely to be a huge, long project with repeated backsliding. As another of Seligman's books suggest, science has not concluded that changing oneself is simple and easy, such as just a couple of self-change methods done in a group (Seligman, 1995).

Perhaps several other self-change methods, applied over months in several areas, would also contribute to appreciating and accepting the past. Consider these additional methods: [Understanding Behavior](#), [Dealing with Anger](#), [Understanding and Forgiving](#), [Relaxation Methods](#), [Empathy Responding](#), [Cognitive Therapy](#), [Determinism](#), [Stopping Bad Memories](#), [Self-understanding](#), and [How to be Happy](#).

In the next step towards happiness, Seligman attempts to brighten our future outlook, like the past, by increasing our positive emotions—hope, optimism, self-confidence, and enthusiasm for things to come. You can measure and understand your optimism-pessimistic beliefs on his [Web site](http://www.authentic happiness.sas.upenn.edu/) (<http://www.authentic happiness.sas.upenn.edu/>). More importantly, if you study the test results carefully, you can see that when you feel optimistic you tend to believe good events have permanent or frequently repeated causes. For example, good actions and events may be seen as due to your own consistent personal traits that have considerable influence. Those conditions will keep the good times coming. Likewise, if bad events are seen as being caused by

temporary, passing causes limited in scope, such as an accidental happening, the reactions of a stranger, a coincidence, or bad luck that day, you have more hope things will be different next time. A pessimist would see a good event as just a fluke, won't happen again, and "I had nothing to do with it." In contrast, optimistic hope is based on seeing good life events as caused by personal traits or by lasting, broad causes which I can perhaps influence. And, an optimist sees unhappy events as having temporary, specific, possibly controllable or unlikely-to-happen-again causes. The next task—a daunting one—might be to reduce your pessimistic thinking and expectations.

Pessimistic, negative thoughts can be challenged by gathering the facts—are these thoughts really true? As we have seen, it helps to look for multiple causes for bad events and ask yourself if changeable, specific, non-personal causes are responsible. Have you instead concentrated on the most dire possible cause? Even if your negative thinking is true and is the outcome truly awful events...is the negative thought useful or does it just cause more trouble? Can less scary explanations be found? Maybe the bad events don't have to happen again. This disputing of one's own negative or pessimistic thoughts is a demanding, difficult process. We can change our thinking but it is seldom easy. This is why therapists are needed in many cases, especially serious ones.

This is good advice as far as it goes, but it is flimsy guidance for making major changes in the infinite thoughts that flit through our minds minute by minute. Moreover, having hope for the future rests on more than reducing pessimism and having hopeful fantasies. What about developing reasonable, doable, testable, exciting plans for the future, as in further education, interesting and gratifying careers, fulfilling social-community service, etc., etc.? What about plans for improving relationships? What about carefully thinking through a set of values and goals you would love to accomplish during your life—actions you feel would be morally laudable and spiritually deeply satisfying? What about testing your ability to analyze problems and make real changes? Proving to yourself that desired changes can be made and self-improvements are not pipe dreams should build your confidence in your self-change skills, your sense of mastery, and change your future. (See [Chapter 3: Values and Morals](#).)

After learning to feel better about the past and more positive about the future, Seligman turns to increasing happiness in the present. He distinguishes in a meaningful way between *pleasures* (eating, having sex, having fun, relaxing, doing exciting things, having enjoyable feelings, being mindful, savoring life) and *gratifications* (engaging in satisfying activities that absorb our attention and make us feel proud or like a good person). Gratifications might include reading/studying hard, doing excellent work, having meaningful conversations, completing an important even difficult task, helping someone, doing the right thing, etc., i.e., not highly exciting but satisfying activities. Both pleasures and gratifications make important

contributions to our happiness but many pleasures soon lose their thrill, so don't overdo having fun and space your fun out over time.

Like Seligman, Csikszentmihalyi (2003) emphasizes in his new book that a very important part of happiness is a worthy, ethical job which is satisfying, challenging, and where you can get into "flow." Remember that [flow](http://www.psychologicalselfhelp.org/Chapter11/chap11_47.html) (http://www.psychologicalselfhelp.org/Chapter11/chap11_47.html) is quietly gratifying and often demanding, pushing our abilities to the limit. Also, be mindful that we often choose the easy way and pleasure over gratification; there are powerful commercial and cultural inducements to maximize the fun we have. Some people feel a desperate need to just have fun much of the time. However, for most people, it is their productive, altruistic activities using their good traits and personal strengths that give us the most satisfaction, i.e. gratification, in life. When you are nearing death, would you be more likely to say "I wish I had partied harder, drank more beer, goofed off more, and done more to have fun?" or say "I'm really glad I showed genuine concern for so many people during my life, that I really worked to develop my good qualities as fully as possible, and used so much of my time, morals and strengths to help others in need?"

From here on Seligman's book is devoted to recognizing your own good character traits, building strengths and virtues, and using them optimally in life's three great arenas: work, love, and raising children. That is a good formula for happiness but there is a great need for more research about this approach:

1. Seligman measures each person's 4 or 5 more important "signature strengths" by using self-ratings, which are notoriously inaccurate (but better than nothing!). See his [Web site](http://www.authentic happiness.sas.upenn.edu/) (<http://www.authentic happiness.sas.upenn.edu/>). Often individuals don't know themselves that well, they exaggerate their strengths and deny their faults. They don't realize other valuable skills; they may think certain weaknesses are strong commendable traits. A review of the specific signature strengths Seligman tries to measure will help you recognize what characteristics we are talking about—and how poorly a couple of self-ratings would measure them: *Wisdom*. Curiosity. Love of learning. Open-mindedness. Good judgment. Practical intelligence. Social-emotional intelligence. *Courage*. Bravery. Industriousness. Honesty. *Loving*. Accepts love. Generous. Fair. Loyal. Leadership. *Temperance*. Self-control. Cautious & prudent. Modest. *Transcendence*. Appreciate beauty. Respect excellence. Gratitude. Optimistic. Sense of purpose. Forgiving. Sense of humor. Zest for life. These are great traits but they are often not accurately measured. Much better tests can and will be developed if objective items and ratings by others are also used.

2. Seligman focuses only on the rated strength of current strengths. What about strengths and values that the person doesn't have now (and would rate low) but would very much like to develop and use in the future?

3. Seligman puts very little emphasis on the individual actually developing (growing) his/her desired traits, strengths and values. Surely learning desired skills and increasing traits, like practical intelligence, industriousness, fairness, self-control, gratitude, optimism, etc. should be part of increasing one's level of happiness.

Consider your career: it is an important part of your life for 30 to perhaps 50 years. Seligman's prescription is to make it your "calling." A calling involves using your best strengths and virtues to achieve excellence in such a way as to be personally fulfilling, respected by others, and a significant contribution to society. The concepts of dedicated involvement and [flow](http://www.psychologicalselfhelp.org/Chapter11/chap11_47.html) (http://www.psychologicalselfhelp.org/Chapter11/chap11_47.html) are very important. He gives encouraging examples of people who have converted their job into a meaningful mission. Changes at work are sometimes possible but for many of us major changes in the nature and goals of our work are impossible to make. We have to make a living and the person paying us expects specific outcomes. As an example, careers in law are discussed by Seligman partly because it is the highest paying profession while lawyers are often unhappy. He says they tend to be suspicious pessimists thinking a lot about avoiding assorted catastrophes that might strike their clients or them personally. The life of a lawyer is generally not filled with doing good and stamping out injustice in the world as they might have thought when they chose the career. More often they are expected to make money, which is often a cynical, selfish, ultimately unhappy pursuit.

Love is another big area of our lives. David Myers (2000) writes "there are few stronger predictors of happiness than a close, nurturing, equitable, intimate, lifelong companionship with one's best friend." To understand your relationships better, Seligman provides a Close Relationships Questionnaire by Chris Fraley and Phil Shaver at (<http://www.authentic happiness.org>). From an early age, we tend to be secure, avoidant, or anxious with others; secure is better. But how do you cultivate feeling secure? It is common in a romantic relationship to see your partner more positively than his/her friends do, called the "romantic illusion." Seeing, valuing, and appreciating your partner's strengths and good points are an important part of a happy relationship. So, dwell on their positive traits, not their faults. View the partner's displeasing acts as being caused by temporary factors (he/she is tired or in a bad mood, not he/she is always a grouch). Nice acts can be seen as due to his/her permanent traits (he/she is caring and bright). Communication skills, especially empathy responding and "I" statements, are vital parts of a relationship (see [Useful Skills](#)). Much advice and many useful references are given in [Love, Marriage & Sex](#).

Many people will tell you that raising a family was the most important part of their lives. Seligman has definite ideas about childrearing. Seligman, Reivich, Jaycox and Gillham (1996) wrote a book, *The Optimistic Child*. Seligman and his wife, both psychologists, have earnestly tried to apply positive psychology while raising their

children. They believe that a child with lots of positive experiences and emotions will inquisitively explore the world and, as a result, learn to master problem situations and develop their strengths. He offers eight techniques for rearing happy children: 1. Sleep with the baby. 2. Give them a sense of mastery through games and play. 3. Say no seldom and yes a lot. 4. Praise worthy accomplishments, not easy ones. Avoid punishment. 5. Avoid sibling rivalry by giving each lots of attention. 6. Focus bedtime rituals on positive experiences—"my best time today" or priming for a pleasant dream. 7. Offer future rewards for self-improvements. 8. Make New Year's resolutions about adding desired behaviors, not about stopping bad habits. There are hundreds of books about parenting and [Family Relations and Child Care](#).

Overall, *Authentic Happiness* is theoretically well grounded in Positive Psychology principles. Sometimes his practical advice seems inadequate to meet the challenge. This is especially so if the child or parent has depressed/pessimistic genes...what do we do then? Seligman acknowledges the power of the genes and then seems to disregard their presence. See *Optimism and Pessimism* by Ed Chang (2002). Yet, Seligman delves into so many aspects of happiness and optimism that the final result of reading his book may be fairly effective in increasing many individual's happiness. The tenor of the sweeping Positive Psychology movement has a little bit of the same feel as the Self-Esteem movement. It goes without saying, of course, that the chapters of the book as well as the whole movement should be empirically evaluated to see how well it increases happiness and/or decreases depression. In general, Seligman's suggestions are as good as we can make today.

OK, so winning lots of money only lifts your spirit for a couple of years. Contrary to the "jolly fat people" notion, getting fat doesn't make most of us jolly. Reportedly, women with breast implants have a higher suicide rate than other women, so perhaps having a nice body won't remove our psychological troubles. Getting into religion may help but the research data isn't entirely clear on that. Is anything a good bet to bring us more happiness? Well, there are a few ideas but they aren't easy to create for yourself and not sure fire even after much effort: (1) Become able to manage your own life doing meaningful things that interest you. (2) Learn to feel truly competent in your major activities. 3. Develop close, meaningful, mutually satisfying relationships. 4. Come to feel good about yourself and the life you have built for yourself.

Finally, [David Myers](http://www.davidmyers.org/) (1993) (<http://www.davidmyers.org/>) summarizes several ways to seek a happy life:

1. Don't make the mistake of believing that being a big success will automatically make you happy. Being a genuinely caring person with good friends is a much better way.

2. Learn to control your time and your behavior. Have a Daily-To-Do List.

3. Act like a happy person—smile, greet people, be outgoing and optimistic, even if you are a little down (Fleeson, Malanos & Achille, 2002). Acting sour and unhappy keeps you feeling that way.
4. Find respected tasks to do that use your talents and challenge you to do your best...flow!
5. Every day do exercises you enjoy to the point of “working out.”
6. Learn to thoroughly rest. Get plenty of sound sleep. An alert, relaxed body feels good.
7. Attend to friends, loved ones, and the people you are privileged to serve.
8. Also, empathize with and respond with help to strangers in need. Happy people are sensitive and giving.
9. Take time each day to remember people and institutions who have helped you. Count your blessings. Express your gratitude.
10. Join caring groups that support your being your best self and give you hope.

Sad to say, we can't suggest how to be happy much better today than Aristotle did 2300 years ago:

“The good of man is the active exercise of his soul's facilities in conformity with excellence or virtue—this activity must occupy a lifetime...one day or a brief period of happiness does not make a man supremely blessed and happy.”

There are hundreds of Pop (not Positive) Psychology books and Web sites about getting happy. They will help some people but there is little research to back them up. There are a couple of research-oriented psychologists who seem to be paralleling Seligman: Baker (2003) and Niven (2000). Stevens (1998) also has a book and a Web site, [You Can Choose to be Happy](http://www.csulb.edu/~tstevens/hcontent.htm) (<http://www.csulb.edu/~tstevens/hcontent.htm>), which is primarily an ad for the book but it does offer selected sections for free. Another Web site is for kids, [How To Be Happy](http://www.geocities.com/howtobehappy/index.html) (<http://www.geocities.com/howtobehappy/index.html>).

Theories about the Causes of Depression



It is enlightening but perhaps discouraging to realize that sadness and its associated depressive symptoms can have many causes. We will review the major theories.

The result of losses

While this is no profound theory, it is more far reaching than you might at first realize. Depression is, of course, the normal, natural reaction when we lose something we value. A friend or loved one dies and we grieve. A loved one leaves us and we hurt, we miss them and want them back. We fail to reach some important goal and we cry. McCoy (1982) lists several triggers to teenage depression: death, separation from a parent by divorce or work, loss of friends by moving, loss of love, loss of dependency and childhood by growing up and joining a peer group, loss of confidence when criticized, loss of traditional values that are not replaced by other guides to living, loss of health, loss of goals (especially after working long and hard for some achievement), poor communication with family, family conflicts, and having depressed parents.

A recent survey at the Medical College of Virginia found that interpersonal losses (death, marital problems, loss of a friend, job loss) remarkably increased the risk of clinical depression in women. But only about 25% of depressed persons have suffered such losses and not everyone who does becomes seriously depressed. Martin Seligman and Gloria Steinem suggest the Baby Boomers grew up expecting the world to be a wonderful place but instead are finding it to be cold and unsupportive. As economic conditions worsen, there is no safety net when we fail--no close family, no helpful neighbors, no concerned co-workers, no church, no kind and gentle government. True, life today has its stresses, but is it more stressful than marrying as a teenager, settling on a remote homestead in 1830, running the risk of death in childbirth or in infancy, and raising a family in the wilderness? I think not.

Yapko (1992) makes the point that your value system and life style (reflecting childhood, friends, and family background) affect your outlook on every event in your life and on everything you do. Your values determine what you see as important and unimportant, as good and bad, as normal and abnormal, and so on. Furthermore, anything you value becomes a potential threat--something you would hate to lose. Examples: If you value being cared for by loved ones (to the extent of being dependent), a scary loss might be graduating from college or getting a divorce. If you value your looks highly, you will lose a lot over the years. If you value financial success but can't achieve it, that is a loss. If you value a close relationship with your children, but they are taken away by divorce, it may be a terrible loss. On the other hand, if you do not value day-by-day some activity (and, thus, don't devote time to it) but psychologically you need it, you have also experienced the loss of something important. Examples: a person, who throws him/herself into either work or child care and avoids the other activity, may only find out years later what he/she has lost.

What are the points here? (a) If depressed, try to recognize the losses you may be responding to. (b) Realize the intimate connection between your values and your regretted losses. (c) Try to reduce your losses, if possible. And, perhaps, join community efforts to reduce other peoples' losses--and thereby reduce your own losses.

Genetic-physiological-chemical

Ancient drugs, like reserpine, cause depression; others, like heroin or opium, cause elation. So there is reason to suspect that some naturally occurring "chemical factors" in the brain could influence depression. Also, the environment is a factor, consider "blue Mondays" and wintertime depression (relieved by full-spectrum lights). Likewise, as we will see, genetic factors clearly play a role, at least in the most serious forms of depression. Even proneness to minor stress and mood swings may be partially inherited. And, physical treatment, like electric shock, may reduce depression. My point again is: the causes of depression are complex and only partially understood.

Note: every once in a while, some amazing finding comes along that shakes your thinking about a mental disorder. (Often the finding is an accidental outcome which doesn't hold up over time, so know about the finding but be cautious.) Very recently (2001) a press release by Stanford University psychiatric team reported that the abortion pill RU-486 had reduced serious psychotic depression symptoms within four days for five women. These women were not pregnant, so this isn't related to having an abortion. The theory is that a hormone, cortisol, is associated with psychotic depression and RU-486 blocks the brain's receptors for cortisol. The drug seems to only help this one disorder. Interesting. More studies are being done. Stay tuned.

Studies of identical twins, fraternal twins, adoptees, and several generations within a family, suggest that your general level of depression is partly inherited but not your level of happiness (discussed in introduction). Your conscious efforts can influence happiness regardless of the messages from your genes. However, if one identical twin has a serious depression, the other twin has a 65% chance of being depressed. Since 35% of the time one twin did *not* become depressed, one could ask to what extent did the nondepressed twin overcome his/her genes? We don't know. Maybe the depressed twin is suffering from psychological causes. Again, we don't know but in dizygotic twins the chance of the other twin getting depressed is only 14%. Kendler, et al (1993) estimates that genes account for 41% to 46% of the variance in depression. Clearly, depression runs in families. The genes and the family environment are both involved, but several studies find that it is *individual*-specific-environmental factors that influence depression and not shared *family* events, such as the death of a parent.

How physiologically do the genes, environment, and drugs influence depression? Current speculation is that these factors

influence the transmission of nerve impulses (involving chemicals called neurotransmitters) in the brain. Too little of certain neurotransmitters (norepinephrine or serotonin) supposedly results in depression, too much in mania or overactivity. Helpless rats shocked repeatedly act depressed and lose their norepinephrine (Ellison, 1977). Rats in a similar situation but able to turn off the shock themselves do not act depressed nor get deficient in norepinephrine (Weiss, et al., 1974).

Another theory is that the "general adaptation syndrome" is responsible for depression as well as stress (see chapter 5). Remember the third stage in this process, after an alarm reaction and resistance, is exhaustion. Depressed people feel tired, drained of energy, "I just can't get going." Other symptoms--poor sleep, appetite, and sex drive--are regulated by the hypothalamus, so it may be malfunctioning. The real question is: What causes the stress or the neurotransmitter or the hypothalamus changes? We don't yet know.

If a person's depression involves radical bipolar mood swings (feeling high and then low), delusions, and a high risk of suicide, some form of medical treatment (drugs and hospitalization) in addition to psychotherapy should be given. If the depression does not include any of these factors but does include other physical factors mentioned above (see signs), medication would probably help (Kocsis, 1981). Even when there are no signs of physical illness, i.e. it seems to be psychological, the treatment of choice is psychotherapy with medication as needed. It isn't understood why or how but anti-depressive medication changes cognition, *and* cognitive therapy, believe it or not, changes body chemistry (Free & Oei, 1989).

Other physiological conditions are related to sadness and anxiety, for example, postpartum conditions, hypoglycemia, and premenstrual syndrome. Hypoglycemia may have been overemphasized in the 1970's but premenstrual syndrome is a devastating problem for some women. One woman was hospitalized 13 times for suicidal depression before someone noticed that each admission was one or two days before her period (letters, *Ms*, p. 4, January, 1984). More commonly (estimated from 20% to 80%), women experience increased tension, headaches, irritability, and sadness prior to their periods. There are likely to be complex physiological *and* psychological causes but we know little about premenstrual stress, thus far. Research is badly needed (Eagan, 1983).

A word of caution: believing in physical causes, such as psychiatrists' favorite expression "chemical imbalance," may interfere with assuming responsibility for changing yourself. Examples: "I'm on medication" or "I get depression from my mother" or "my system is all messed up." Lewinsohn & Arconad (1981) reports that many depressed patients see themselves as physically ill, as victims of some bodily disorder. Thus, they expect the "doctor" or medicine to magically remove their sadness--otherwise, they feel helpless. (Of course, the opposite misunderstanding is equally harmful: when

physically caused depression is treated with psychotherapy, prayer, illegal drugs, alcohol, talking to friends, self-help....) Don't neglect the possibility of either physical-chemical or psychological-environmental causes.



The very idea that drugs are the answer (to depression) suggests a moral, psychological, and spiritual vacuum.
Peter Breggin (1994)



Poor social skills = no fun

One social learning theory (Lewinsohn & Arconan, 1981) proposes that depression is a result of an unrewarding environment and the person's reaction to it. This is like the loss theory (1) except there is a twist: the "depressing" environment may not be painful, it may just not be any fun--it provides no pleasure, no "positive reinforcement." That could be depressing!

Lewinsohn and his associates have shown that depressives respond slower and less often to others. They don't get others to respond to them; thus, they get fewer social rewards (less fun) than nondepressed people. More importantly, depressed people arouse more anxiety, anger, depression, and rejection in others than "normals" do (Coyne, 1976). How? By too many complaints, requests for support, and premature discussions of personal problems. This may account for staying depressed but it doesn't explain why the social interaction and skills decline.

Coyne suggests that this sequence of events occurs: (a) some stressful events happen, (b) depression-prone people need more social support and nurturance than others when under stress, (c) but they have fewer social skills for getting the extra support needed, which worsens the depression, and (d) they start relating in ways that drive others away, which maintains the depression. Indeed, 70% seeking therapy aren't getting what they want from their spouse (McLean, 1976). Some questions still remain about this theory: Why do they need more support? Why do they lack these skills? Why can't or don't they figure out how to have more fun?

Recent research has studied which behaviors of depressed students drive roommates away (Joiner, Alfano, & Metalsky, 1992). Tentative findings are that depression per se doesn't turn people off, but certain behaviors by self-deprecating depressed people do, such as *excessively seeking reassurance* that the other person cares. This is true especially between males. Obviously, how the depressed male is received also depends on the characteristics of the "friend." For

instance, an empathic, tolerant, caring person would not be rejecting, except under the most trying circumstances. Perhaps males are rejected more for seeking support because they are supposed to be self-reliant and "suffer in silence." Perhaps depressed women are rejected for other reasons. In any case, there is clear evidence that a depressed friend is depressing.

Ferster (1981) says the depressed person is so overwhelmed by their loss and anger that they can't respond effectively to the environment (to others) to get what they want. Rather surprisingly for an operant behaviorist, he implies this insensitivity to how-to-get-what-we-want may come from early feeding experiences where the infant responds more to the internal urge to eat (making demands-- which get reinforced) than to interacting and playing with the feeder. Like the fussy, demanding baby, the depressed person becomes fixated on complaints, criticism, demands, and loud cries of distress (all punishing or aversive to any listener). Instead of seeking positive reinforcement, they have learned to only punish and complain; they hurt too much to do otherwise (like the hungry infant). By being so glum and critical (and insensitive) they only drive others (sources of fun) away. By therapy or self-education they must learn other ways of interacting.

Lewinsohn's approach to therapy is to first pinpoint the punishing events present in the sad person's environment (usually marital problems, work hassles, or criticism) and the pleasant events absent (including friends, love, sex, fun activities, satisfying solitude, and feeling competent). Then by careful, daily rating and plotting of one's behavior and the resulting feelings, the therapist shows the depressed person that the environment (and how they handle it) truly does determine their depression. Treatment consists of teaching the patient how to decrease the frequency and hurtfulness of unpleasant events and increase the frequency and appreciation of pleasant events. This is done by using many techniques, like those in chapters 11, 12, and 13, but mostly behavior change or social and cognitive skills to increase positive reinforcement. The University of Oregon started a class in "Coping with Depression" (Lewinsohn & Arconad, 1981).

You might notice that this is the same basic notion as most dynamic psychiatrists operate under, namely, that most emotional problems originate in our interpersonal relationships. Surely it would work in the opposite direction too: if I became very sad, impatient, demanding of attention, lethargic, and grouchy, I'd surely develop interpersonal problems. So which comes first, sadness or poor social skills? Have life events been painful or just no fun?

Recent research confirms the importance of positive experiences

We therapists and writers focus on reducing unpleasant negative emotions--anxiety, fears, depression, anger, dependency and so forth. We do this partly because patients frequently have gotten into a sink

hole of obsessive scary, irritating, or sad thoughts and feelings. Also, our therapy methods are oriented toward reducing symptoms. Research, however, has shown that positive thoughts and experiences reduce the negative reactions we have to stress, loss, frustration, and helplessness. Therefore, distress and unhappiness can be reduced by using a variety of pleasant, satisfying or promising coping methods, which are different from traditional therapy methods. Note that how well we cope is related to (a) perceived characteristics of the upsetting situation, such as how changeable the situation is seen to be, (b) personality factors, reflecting such traits as optimism, self-efficacy, toughness, a sense of humor, and neuroticism, and (c) social resources the person has, such family support, a devoted friend or therapist, a fun group, etc. (Folkman & Moskowitz, 2000). To some extent these factors are within our self-control.

What other coping methods might indirectly ease the pain of fear or depression? One would be *cognitive reappraisal* or "reframing" or "benefit finding." If there is one little bright spot, a ray of hope, or one good thing, the situation is not so bad. You have to look for the positive, however, so that you will not be overwhelmed by the gloom. In bad situations, such as caring for a sick loved one, the bright spot may be the satisfaction you feel about your steady contribution to their care. Don't dismiss the good. And, at the other end, don't over-estimate or reinforce the bad feelings (see [Becoming Absorbed with One's Wounds](#)).

Another aspect of coping that yields positive feelings is the fact you are trying to improve the situation. *Problem-solving efforts* focus our attention on the important and changeable aspects of the distressing situation, motivate us to try something, give us satisfaction when we try, and lead to mastery and pride if we have some success.

A third way to see the positive is to ask yourself "did I do something that made me feel good?" Most people can find some things, but you have to look for them and remind yourself that even in the midst of an awful situation good things are still happening. So, in the footsteps of Lewinsohn 20 years ago, today's cognitive therapists often ask their patients to schedule positive events and to look for positive meaning. The more positive events and experiences we can have, the more we reduce the depression (Dixon & Reid, 2000).

Helplessness and hopelessness

Being frustrated so many times that you have no hope is surely depressing. This is a very old idea; 2,000 years ago Aretaeus, a physician, said melancholia sufferers "complain of a thousand futilities." But it is also a fairly recent and rapidly changing theory. Seligman (1975) was studying escape learning and found that dogs, forced to stay in a box where they were repeatedly shocked, soon gave up and stopped trying to escape. Not surprising. Moreover, 65% of the dogs didn't try to escape the next day when the box was modified so they could easily escape. They just laid down and whined.

They had learned helplessness. Seligman said human depression with its passivity and withdrawal might be due to "*learned helplessness*."

This single study of dogs stirred enormous interest among experimental psychologists who had heretofore ignored the ancient idea of hopelessness. Amazing. However, I think we are seeing the potential of research to slowly clarify and validate an idea. For example, within a few years the "helplessness" theory was being questioned because many people in helpless circumstances do not become depressed and because this theory does not explain the guilt, shame, and self-blame that often accompanies depression. How can you feel helpless, i.e. without any ability to control what happens, and, at the same time, feel at fault and guilty about what happened (Carson & Adams, 1981)?

A few years later, attribution and/or cognitive theory (Abramson, Seligman, & Teasdale, 1978) came to the rescue with the *reformulated helplessness theory*. This suggests that the depressed person thinks the cause is internal ("it's my fault"), stable ("things can't change"), and global ("this affects everything"). This is a very different theory (no experimentalist had ever theorized that the dogs blamed themselves). But soon there were more problems, e.g. research showed that most depressed people, like dogs, see the causes of their depression as being outside forces, not themselves (Costello, 1982). Moreover, both the hopeless self-blamer and the hopeful self-helper see the causes of their behavior and feelings as being internal. So, internal causes may lead to optimism as well as pessimism. And, finally again, how do we know that the feelings of helplessness or hopelessness precede and cause depression rather than just being a natural part of feeling depressed?

To deal with some of these difficulties, Abramson, Metalsky, & Alloy (1989) modified the helplessness theory into a still broader hopelessness theory. The more complex *hopelessness theory* contends that prior to becoming hopeless the person has (a) a negative cognitive or attribution style (see next two theories) and (b) some unfortunate, stressful experience. Because both of these factors are involved, some people with depression-prone thinking don't become depressed (by avoiding traumatic experiences) and some people go through awful experiences without getting depressed (by avoiding negative thinking). *The hopeless person expects bad things will happen* in important areas of his/her life (pessimism) and/or that hoped for good things will not happen, and he/she doesn't expect anything to change that miserable situation.

Considerable research has supported parts of the hopelessness theory. For example, Metalsky & Joiner (1992) found that *three cognitive views*: (a) attributing bad events to unavoidable and far-reaching causes, (b) drawing negative conclusions about yourself from a negative event ("it means I'm worthless"), and (c) assuming one bad event will lead to others in the future, *when combined with high stress*, are associated with depression. In another study, they found

that *low self-esteem* was another crucial ingredient in order to produce depression (Metalsky, Joiner, Hardin & Abramson, 1993). Please note: depression might be avoided by reducing your negative thinking habits, avoiding high stress, or by building your self-esteem.

Of course, your needs and personality will determine how stressful a particular event will be for you. Segal (1992) found that recovered *dependent* depressives were plunged back into depression by a loss or conflict in interpersonal relationships. But, *self-critical* depressives relapsed when they failed at school or work. Only our most dreaded problems seem to set off depression.

This new hopelessness theory explains depression to a considerable extent on the basis of pessimistic *expectations of the future*. Traditional thinking and other theories (#1, #5, #8, #9, #10 & #13) say depression is caused by obsessing about losses in the *past*. Selective perception of the past is also thought to be important, e.g. self-critical people don't see their successes. Both backward-looking and forward-looking theories are probably true, sometimes. Some people regret the past ("Of all sad words of tongue and pen, the saddest are these, 'it might have been'") and others dread the future (because they will mess it up or have no control), and some do both. Maybe the negativism of some depressed people extends to everything--the past, the future, me, you, the world...

As we will see later, the therapy for helplessness and hopelessness includes (a) making more good things happen and/or increasing positive expectations, (b) increasing self-control--like with this book, (c) increasing tolerance of whatever happens, and (d) increasing one's optimism. Ideally, the depressed person will develop internal, stable, and global explanations (attributions) for *good* events, e.g. "I'm responsible for what happens, and I can make good things happen again in lots of areas." Likewise, the shift should be to believing that external, unstable, and specific factors account for unpleasant life-events, e.g. one of Seligman's better adjusted dogs in the shock box might say, "This man is hurting me, he will surely stop soon, people only shock me in this box... and I will vigorously avoid getting into this box again. For now, I'll just tough it out."

Exercise: How do you explain things?

It might increase your understanding of your own depressive moods to think of 8 or 10 situations that could happen to you--both good and bad. Examples: doing poorly on an exam, getting a good job or a promotion, having an auto accident, not being able to get a job, getting a new friend, having a date that doesn't work out, losing a girl/boyfriend, having a fight with a parent, relative, or child, etc. Vividly imagine each situation, then, afterwards, write down what seems like the main reason or cause for what happened. Next, ask yourself: (a) Is this cause due to me or someone or something else?

(b) Is this cause going to influence just this situation or many others as well, i.e. how general or how limited is the influence of this factor? (c) Is this cause a temporary factor or long-lasting? (d) How important is this situation to me? (e) When bad things happen to me, do I conclude I am at fault or bad? (f) When something bad happens to me, do I assume more bad events are on their way? By looking at your answers over several situations, perhaps you can figure out your *attributional style*. Are you a pessimist about the future? Are you a harsh self-blamer? What do you think your faults are? Do you blame your behavior ("I didn't study enough"--this is changeable) or your character ("I'm lazy" or "I'm stupid"--hard to change)? What are your strengths? How low is your self-esteem? Do you see ways to change?

There are even more good questions you can ask yourself that should help you realize that your depression can be changed (Johnson & Miller, 1994):

- **The Exception Question:** When are you the least depressed? What was the last time you weren't depressed (or down on yourself)? Do you remember a time when you expected to get depressed but you were able to avoid it? These kinds of questions remind you that you have some self-control... that depression can be changed. They cause you to start exploring the reasons for these changes--what was different? How can you reduce the depression again?
- **The Miracle Question:** If the depression (or self-critic) miraculously went away, how would life be different for you? What would be the first sign it was gone? How would others say you are different? What would you be doing instead of being depressed? *Be very specific* about how your behavior and feelings would be changed. What are some of the exciting possibilities if you were not burdened with depression? This starts you thinking about your potential in the future as a happy person.
- **The How-Did-You-Do-It Question:** Depression is an awful condition, how have you managed to handle it? How have you kept things from getting even worse? How do you fight off the conditions that make you get really depressed or to want to hurt yourself? Where do you get the strength to be a survivor? These questions cause you to look for your specific strengths and for other ways to cope with depression. They also help you see that depression is not caused by you and is not an unavoidable part of your being. Depression and self-putdowns are external problems imposed on you by psychological or historical factors and circumstances. These misery-causing external factors can be changed.

However, there are still serious questions about this hopelessness theory: When and how are negative thinking styles learned in real life? Again, which comes first the thinking or the feelings? Isn't it illogical to feel responsible for making good things happen but not responsible for bad events (although that is the way we frequently think about God--

we give God credit for good happenings but usually not the blame for bad things)? Do hopeless depressives only feel guilty and ashamed of sins of omission? Wouldn't sins of commission be impossible for me as a truly "helpless" person, unless I was possessed by evil external forces that "made me do it" and with whom I collaborated? Begins to sound like a 1620 witch hunt, doesn't it? (See later discussion of guilt.)

Actually, the victim of depression may feel helpless, but his/her emotions, weakness, and pessimism can have a very powerful effect on others. Examples: the typical "helpless" person "asks others to do things for him/her," "never does things on his/her own," "gets others to make decisions," etc. This is helpless? Hardly, it is dependent, demanding, and controlling (Peterson, 1993). These "helpless" feelings also serve as self-excuses for poor performance (for many of us it is better to be seen as "feeling down" than as a failure). But only persons prone to depression are willing to be extremely self-critical ("I'm a loser... helpless... worthless") in order to protect themselves against criticism and to avoid facing future responsibilities (Rosenfarb & Aron, 1992).

How do people respond to someone's helplessness? At first, people try to make the person feel better; they try to meet his/her needs. But after seeing a lot of "helpless" behavior from one person, people tend to get angry and/or avoid the subtly (maybe inadvertently) demanding depressed person who never changes. Clearly, not all "helpless" people are passive, ineffective, and feeling futile, like Seligman's dogs. Some are powerful. Seligman's latest views are in Peterson, Maier & Seligman (1993).

Yapko (1992) believes that depression not only results from an "illusion of helplessness" but also from an "illusion of control." For instance, Baby Boomers were taught they could have it all--education, great job, wonderful family, nice house and car, fantastic travel, etc. That wasn't true and Baby Boomers have an unusually high rate of depression. They didn't meet their expectations. Unrealistic expectations in both directions, i.e. hoping for too much change or believing little change is possible, can cause depression.

Negative views

Beck's cognitive therapy states that somewhere in childhood the depressed-to-be person develops a negative view of the self, the world, and the future: "I'm no good," "the world ain't fair," and "it won't work out." Each of these negative views gets expanded into detailed beliefs: "I'm dumb," "I can't talk intelligently," "I'm ugly too" and on and on. These negative assumptions seem to be held on a very primitive level; facts don't influence these beliefs, so they never get questioned or tested against reality. For a brilliant investigation of the development of self-critical beliefs at an early age, see Carol Dweck's studies of [mastery-oriented thinking](#). These negative views just lie dormant even while more rational evaluations of self, world, and future may also be developed and used as we mature into adults. Then later

in life, when the self is hit with some serious loss or stress, often one that reminds us of a loss or trauma at an early age, the old unreasonable and destructive negative ideas suddenly take over and dominate our thinking. It is our negative ideas that produce our depression, not the stressful triggering event that produces our depression. The deeper the depression, the more the negative ideas replace rational thinking (Coleman & Beck, 1981).

Under the influence of this primitive, negative thinking, our logic fails us. For example, we jump to conclusions, look at only one detail and disregard the big picture, overgeneralize from one experience, magnify our faults and minimize our achievements, and take the blame (see examples in next two theories). All of this adds a very dark and gloomy shadow over our mental life.

Research has confirmed that sad-prone people notice the negative aspects of an event (they remember their goofs--but not other peoples'--and overlook what they did right) and assume too much of the responsibility when things go wrong. It has also been experimentally demonstrated that thoughts (induced by the experimenter) can influence feelings and behavior (Carson & Adams, 1981). Therefore, it isn't just the depressing event that makes us sad but also every time we remember and fantasize about the disappointing event in the past or imagine a similar thing happening in the future, we create a more and more depressive mood. Remember, though, negative cognition clearly *accompanies* depression but it has not been proven that negative thinking is the exclusive *cause* of depression; other factors may be involved in causing depression (Barnett & Gotlib, 1988).

Using methods much like Lewinsohn's, cognitive therapists collaborate with the patient to get him/her to investigate the relationship between his/her negative ideas and his/her feelings of depression or actions. So, the therapist may ask the patient to "investigate" whether or not he/she can start taking tennis lessons. If he can, that is a little evidence against his belief that he/she can't change anything. A few weeks later patients are taught to identify their automatic negative thoughts that precede negative feelings. The cognitive therapist does not attack the patient's irrational ideas as being wrong. Only after the patient begins to doubt some of his/her own negative ideas, can the validity of those thoughts (and the logic and assumptions underlying them) be tested out and evaluated *by the patient* with help from the therapist (Coleman & Beck, 1981).

Cognitive therapy notions about negative thinking overlap a lot with the hopelessness theories, Rational-Emotive therapy (irrational ideas), and faulty conclusions theories discussed later.

Irrational ideas

Rational-Emotive therapy, as described by Ellis & Harper (1975), Hauck (1973), and Maultsby (1976), emphasizes that irrational ideas cause all our unreasonable or excessive emotions. In the 1st century A.D., Epictetus, a Greek teacher enslaved in Rome, said, "Men are not disturbed by things (that happen to us), but by the views which they take of those events." In the 1960's Albert Ellis started teaching this simple philosophy: *our thoughts cause our feelings*. Here is an example:

A. First, there is an event: our girl/boyfriend says, "I'm going out with someone else."

B. Then, our belief system--our irrational ideas--become part of our perception of the situation:

(1) She/he doesn't like me, I've failed, no one will want me, I'm worthless, I'll never find as good a lover, it's terrible that he/she is dumping me. Or:

(2) It's awful that she/he would do that, it's inconsiderate, it's selfish, it's unfair, it's embarrassing, it's mean, she/he is a terrible person, we made promises, she/he has probably been "looking" for a quite a while, I hate her/him.

C. Then, we have an emotional reaction:

(1) If your belief system (thoughts) is like B (1), you will feel serious and lasting depression.

(2) If your belief system is like B (2), you will feel intense anger.

You see, it is not the external event--the rejection--that creates the emotional response, but what we say (beliefs B 1 or B 2) to ourselves! We have a choice. Indeed, we could tell ourselves something entirely different and produce a very different emotional reaction, for example:

B. A more rational belief system:

(3) We had some good times together but obviously there were problems. I would have preferred that she/he had told me that she/he was unhappy and "looking" but it wasn't awful. I'm sorry we didn't work it out but I'll get through the hurt, and I'll learn to be a better companion next time.

C. A more reasonable emotional reaction:

(3) Some pain, regrets, and sadness for a few days or weeks but not intense, lingering anger or deep, prolonged depression.

Rational-Emotive therapy is more challenging and aggressive than most other therapies. These therapists immediately point out and attack the client's irrational thoughts and unreasonable expectations. They directly suggest more reasonable ways of viewing the self, the world, and the future. They also assign homework designed to correct false beliefs.

What are some of the other harmful irrational ideas and thoughts?

- Everyone should accept and approve of me; it is awful when someone criticizes me.
- I should always be able, successful, and "on top of things."
- I must have love to live (in some cases--a particular person's love, as in the example above).
- If I am criticized or rejected or make a mistake, it means I'm not liked, unlovable, and incompetent...it's awful!
- External events, such as bad luck, other people, a sick society, cause unhappiness. I can't control these things, so it's not my fault things are so awful.

Note two things: first, a, b, and c are unreasonable expectations, often impossible goals. They are, of course, nice, common and in many ways useful wishes; everyone would like to be approved, successful, and loved, but we can't demand that our wishes always come true. When things don't go our way, it isn't something awful to go into a rage or deep depression about. Although an event may be regrettable, it is always a psychologically understandable and behaviorally lawful outcome. Later we will see that Karen Horney referred to these insistent neurotic needs or demands that things be the way we want them to be as "the tyranny of the shoulds." Secondly, d and e illustrate other kinds of faulty logic that might underlie depression (see cognitive therapy) and other exaggerated emotions. Rational-Emotive techniques and self-help methods are discussed in chapter 14.

Some scientists doubt that irrational ideas and faulty logic cause depression. Some doubters believe the sad feelings existed *before* the sad-helpless thoughts, i.e. that depressing genes or hormones or life events lead to our negative cognitive styles (Barnett & Gotlib, 1988). Other doubters, like Robert Zajonc, believe that emotion and cognition are independent systems and, furthermore, irrational behavior is based on emotions, not irrational thoughts (Cordes, 1984). In spite of criticism, cognitive explanations are the most accepted explanations of depression among psychologists today.

Unreasonable thinking and faulty conclusions

Depressed people are prone to think in several ways that may produce sadness and pessimism. If things have gone badly in the past (depressed people are past-oriented), there may be a tendency to conclude that the future will be awful too. Actually, depressed people usually don't think much about the future. The future is depressing precisely because it has little meaning or no purpose for them... or is threatening. The erroneous belief that things will not get better may lead to suicidal thoughts. This hopeless vision of the future is based on a general global perception that their problems are huge, innumerable, and insolvable. A depressed person may have only a vague notion of wanting "to be happy," "to put my life back together," "to find love and happiness," etc. Of course, without the problems being definable, objective, specific, manageable, and circumscribed, depressed people don't have specific plans, i.e. doable, clear-cut, self-help steps in mind for attaining realistic goals. Without plans for changing, they have no hope and no motivation. They feel like victims, not masters of the situation. That is unreasonable. They can change.

Depressed people seem to reason poorly in several other ways. Examples: they are concrete thinkers and have difficulty generalizing (e.g. after being taught to be assertive with his/her boss, he/she doesn't think of being assertive with his/her spouse). They see nothing illogical about giving credit to luck, other people, God, fate, etc. for the good things and blaming themselves for the bad things in their lives. While depressed people focus on the bad happenings in their lives, some of them tend to deny the "bad" emotional parts of themselves, such as anger, violent, and selfish urges, etc. Others see only the bad. And, their "solutions" for their problems are often unrealistic, such as a person with two children and an unhappy marriage who wants to have another child "to improve the marriage" or a floundering overly critical student decides to drop out and live with his/her father although they have never related well. We can't cope well without thinking straight; this includes having a purpose and a plan for living (see chapters 2 & 3).

There is still more wrong with the depressed person's thinking processes. Therapists and scientists studying the brain have contended that a part of our mental make up compels us humans to explain everything (see attribution theory in chapter 4). Some of us, hating uncertainty, need an immediate, simple, "it's for sure" explanation; others of us need lots of data, time to weigh different opinions, and careful thought about the issue before we arrive at an explanation. This reflects the difference between simple "black-and-white thinking" (dichotomous thinking) and complex "tolerance of ambiguity." Depressed people grab hold of immediate, clear-cut but pessimistic explanations; that is their "explanatory style," namely, "it's my fault" (happy folks blame the situation or someone else), "my weakness messes up everything" and "it will never change, so why try?" Wow, what a prescription for depression! Reality is: you aren't entirely to blame, the supposed fault won't mess up everything, and the

situation--including you--can and will change. Depressed people must learn to think differently.

We need to understand why some depressed people are such rigid and poor thinkers. It is critical knowledge for working with suicidal patients. The closed-mindedness of depressed people is amazing. Yapko (1992) describes counseling a patient who recently had a heart attack and a quadruple bypass. This man wouldn't talk or open his eyes during the first hour of therapy; he quietly cried while his wife told his story. When the patient finally talked in the second session, he only said, "I'm going to die!" and sobbed. He could do nothing and think of nothing but dying. In contrast, Viktor Frankl survived the brutal conditions of a Nazi concentration camp, while many died, by intensely desiring to live so he could be re-united with his wife. He had a purpose and thought there was some chance if he could stay alive. We must use our rational mind to find those rays of hope and to develop realistic plans to make our future better.

Self-critical withdrawal

If we are sad, we respond more slowly and avoid ordinarily pleasant (it may not be pleasant to the depressed person) and unpleasant events. Indeed, there is evidence that depressed people are especially sensitive to pain and even mildly irritating situations (Carson & Adams, 1981). Perhaps because of this sensitivity, some depressed persons have developed unique ways of reducing pain or stress in addition to avoiding or withdrawing, namely, by making self-critical or self-hurtful remarks (which may reduce criticism from others or, in some masochistic way, reduce the stress). This sounds a lot like the story of Sooty Sarah below. The outcome could be a miserable recluse.

We need to understand why some depressed people are such rigid and poor thinkers. It is critical knowledge for working with suicidal patients. Forest and Hokanson (1975) did an interesting study supporting the notion that self-punishment could be rewarding, i.e. an escape from conflict with someone else. In this study an aggressive partner was permitted to shock depressed and non-depressed subjects. Then those who were shocked were given the choice of shocking their partner back, shocking themselves, or making a friendly gesture to the partner. If the depressed subjects elected to shock themselves, their autonomic responses (stress) declined more rapidly than if they were aggressive or friendly. Non-depressives got relief only by shocking the other person, not by self-punishment or being friendly. For most of us, it seems astonishing that anyone would hurt themselves more after being hurt by an aggressive SOB. Well, there seems to be some relief--a payoff--for depressed persons if they punish themselves instead of attacking the aggressor. Maybe sadness is partly a self-punishment (and/or substitute for aggression). This needs to be understood better and may also be involved in the next odd-sounding theory.

Anger turned inward

Psychoanalysts have long believed that anger towards others gets turned against ourselves. Our anger converted into self-hatred causes depression. Karen Horney (see Monte, 1980, or any theories of personality book) wrote that the basic problem starts with neurotic parents who are inconsistent (both overindulgent and demanding), lacking in warmth, inconsiderate or openly hostile, or driven by their own needs. The child resents these things. But parents are powerful and a child's only means of survival. So, because of fear or love or guilt, the child represses the anger. The child, being small, alone, confused, and helpless in an unpredictable, hostile world, is, of course, scared. How does the child protect itself?

The child, aware of his or her weakness, the criticism of others, and his or her own hostility and fears, develops a "despised" self-concept. Also, the resentment of others has been turned against the self: "I am unlovable, a bad person." At the same time, the child starts to develop a notion of an "ideal" self--what he/she *should* be--in order to survive and get the love and approval he/she wants. This ideal self, trying to compensate for weakness and guilt, sets up impossible demands, called neurotic needs. These needs are unconscious, intense, insatiable, anxiety-causing, and out of touch with reality. For instance, if one has a neurotic need for affection, it becomes urgent to be loved by everyone, all one's peers, all the family, teachers, the paper carrier, etc. Horney listed several neurotic needs, primarily needs for perfection, power, independence, and affection. All are attempts to handle the primitive hostility from childhood. So, how do we get depressed?

In extreme cases, some people become so self-effacing, i.e. compliant, unselfish, and modest; they almost do away with their "self." Suffering, helplessness, and martyrdom are their ideals. They need to be loved, liked, approved, important, but taken care of. Their "solution" is: "If you love me, you will not hurt me." But beneath this saintly, goody-goody surface sometimes boils the old anger, rage, and strong urges to be aggressive and mean. Besides, love never runs smoothly--remember everyone must love them--so these kinds of dejected people may turn against themselves, becoming very self-critical and unhappy. Often they have also become bitter because the unwritten agreement was broken, namely, "I'll be nice and not hate you, if you will love, respect, and care for me always." People striving for sainthood often suffer because others will not always put them first.

Warning: Some words in this story may offend you. Skip it if you are sensitive about "dirty words."

Sooty Sarah: A fairy tale

Chapter One

Once upon a time there was a poor little girl who couldn't do anything right. She lived with a wicked queen, her stepmother, in a cold, gray castle. Sooty Sarah knew she never did anything right because no matter what she did, the wicked queen (who had had an evil spell put on *her* by an old witch) always found something wrong with it. (You need to know that the old witch had slipped a pair of shit-colored glasses on the queen, but she didn't know they were there because they weighed nothing. Since Sooty Sarah had never seen the queen without the glasses, she never asked about them. She just thought the old queen hated her which wasn't necessarily so. But back to the story.) Things went on this way for some time. The little girl trying to please the queen and the queen continually finding fault with her. Then, one day, when the little girl was older, she noticed the queen looking very pale and sick. "What is the matter?" she asked. "My, aren't we nosy!" said the tired queen, "Well, if you must know, I have to stay awake nights thinking of things to criticize you about. You're a very difficult child to criticize, you know." Sooty felt very badly and said, "Oh, I'm sorry, I'll try to make it easier." Being a good girl, she started to do all sorts of stupid little things. Actually, things went well for a while--the girl misbehaving, getting the queen's attention, and the queen criticizing the growing girl loudly. Everyone was miserable but satisfied. But all good things must come to an end. The queen's health began to fail again.

Chapter Two

The little girl noticed right away, but she couldn't think of any new ways to be bad, so she thought and thought. Finally, she had a plan and ran to tell her stepmother right away. "I have it," she cried, "I know how you can get all the sleep you need. I'll criticize myself!" "That may be a good plan," said the queen, "it may be the best idea you ever had." Sooty Sarah was overjoyed; finally she had done something right. "You can still criticize me if you like, but I'll take over the real work," she said and rushed off to study hard at finding fault with herself. (As she got better and better at it, two things started to happen. Little glasses started to grow over her eyes too and a wall, one stone at a time, started to build up around her. The wall was always there; it went with her. Like a chimney, the wall hid and protected her from the world, which was scary because by now Sooty Sarah was not only finding fault with herself but with everything in the world as well.) Sooty Sarah found lots of faults--bad thoughts and feelings the queen could never have found--and the queen slept happily ever after.

Chapter Three

While all of this was going on, there was an ugly frog nearby who was firmly convinced that he was the most despicable creature on earth. But a wandering wizard happened to meet him one day and whispered a magic spell into his ear. All of a sudden the frog turned into a handsome prince.

Chapter Four

One warm, sunny day, the prince noticed a strange-looking stone chimney with a few peep holes in it. Being curious he looked in and, to his surprise, found a beautiful princess. "Hello, princess," he said, "how did you get trapped in there?" "Who are you talking to?" said Sooty Sarah. "You, of course," he said. "You are out of your mind," she answered, "I'm a dirty, stupid, mean little girl, not a princess--but since you mentioned looks, I don't mind telling you, you look shitty."

"Ah, I know what's wrong, you're under an evil spell," said the prince. "You're crazy," she responded, "and if you don't leave me alone, I'll really tell you what I think of you." "Your words don't hurt me, I'm going to stay and try to help you break your spell," he said. "Spell, Schmell," she shouted, "I hate you bastards who look at everything through rose-colored glasses!" "But, I'm not wearing glasses," he answered.

Chapter Five

"Hum, you're not are you!" Sooty Sarah said, "OK, if you're so smart, mister prince, tear down this wall, break my so-called spell, rescue me, big boy!" "I can't do that," he answered, "Only you can do those things." "Some prince!" she scoffed, "You couldn't prince your way out of a paper bag!" The prince was patient and said, "I just know that if I tried to do it for you, the walls would get stronger and the glasses dirtier and you'd end up criticizing yourself more. You have to do it. I know a counter-spell but you have to have the courage to use it. If you do, it will turn you into a princess so we can be married and can live happily ever after." "Good line, mister, but it will never work," Sooty Sarah said softening a little, "I don't deserve to be happy!" "Yes, you do," said the prince, "I know because the old wizard told me so." With surprise, she responded, "Did he really say that? (the prince nods) Then please help me if you can. You don't know what's it's like to lie awake nights thinking of terrible things about yourself--it's awful!" "I do know," he said, "before I learned the counter-spell I was an ugly frog!"

Chapter Six

"No foolin'?" she said. "It's true," he replied. "Then please, please help me. Tell me the magic words and I'll say them--I'll do anything," she pleaded. The prince leaned over very close to her and whispered the words in her ear. "Oh, no! I can't say that!" she gasped, "That's

terrible!" "I didn't say it would be easy, did I?" said the prince, "But that's not the hardest part--you've got to keep saying it over and over, louder and louder until the spell is broken. If you weaken and quit, it will make things worse--you would end up even more hurt and angry than you are now. Is it worth the risk?" Quietly she said, "I'll try." "Good, you're half way home," smiled the prince, "But there's another part of the spell I can't tell you. You must figure it out by yourself, then the spell will be over."

Chapter Seven

"Now, recite the magic words," urged the prince. Sooty Sarah felt scared, she hesitated, then she whispered so softly he could barely hear her say, "Go to hell, Mother." "Louder," he said. "I can't," she said, starting to cry. "But you must," he said, "do it for me, we can't stop now. Say it again!" Trembling, she spoke the counter-spell again: "Go to hell, Mother!" and again louder, "Go to hell, Mother!" Inside her heart there was a terrible wrench; she thought she would die. It was the old queen waking up and her voice from within screeched, "How dare you! You awful child! I'll get you." Sooty Sarah yelled back, "I just want to be happy!" "Say it again," encouraged the prince. "Go to hell, Mother!" screamed the girl. "You terrible child!" shouted the queen in fury, "I'll destroy you." "Go to hell, Mother!" "Good, keep it up," said the prince. The raging queen thundered, "Look at the misery you've caused me. You don't deserve to be happy! Whoever said you should be happy?" "The prince did," said the girl. The queen smiled. "Who says so?" asked the prince. "The wizard says so," said Sooty a little uncertain. The queen laughed. "Who says so?" repeated the prince patiently. "I, I, /SAY SO!!" she shouted, "I say I deserve to be happy, so Go To Hell, Mother! GO TO HELL, MOTHER! GO TO HELL, MOTHER!"

Chapter Eight

Then a miracle began to happen. Every time the girl said the words, the wicked queen began to shrink. She shrank down and down way inside the girl until she was hot like a tiny coal. And she glowed red hot, down dark inside, tiny, but very angry red. Sooty Sarah knew she had not won yet. "But what can I do?" she begged the prince, "What's the rest of the spell? Please!" "You've got to figure it out yourself...and it isn't easy...and half is something you must tell your step-mother...and they are words you have never spoken to anyone in your life," he said and then added, "You must be quick--it's now or never."

Chapter Nine

The poor little girl thought and thought--what could she say to herself and her mother that would be words she had never spoken before? The coal inside her stomach was getting redder and redder. Time was running out. At that moment the prince leaned over, touched her hand and said, "I love you." Suddenly, like a flash of

lightning, she knew what to say. "Oh, Mother," she cried, her tears falling down inside her onto the coal, "I know what to say! I'm OK!" Then she screamed:

"I'M OK and YOU'RE OK!
I'M OK and YOU'RE OK TOO, MOTHER!"

Now it seemed so simple. The minute she said it, she knew it was true--she really was a princess! And the wall vanished. The glasses fell away--and she knew she would never have to criticize herself again for her mother's sake. And she knew that *if* she could only know her step-mother's needs and suffering and sorrow, she would understand her criticism and not be angry with her. And she knew that no matter what she ever did, she would always feel OK about herself.

Chapter Ten

So, she married the prince. And it was a beautiful world.

The Sooty Sarah story, except for a few modifications by me, was given to me by Paul Shriver, a colleague of mine. Some readers are so distracted by the "dirty" words and hostility towards the mother that they miss the main points. First, self-criticism may be learned by modeling the mother *or* via negative reinforcement (avoids the mother's criticism) *or* by being praised and reinforced by the mother *or* by the above-mentioned reduction of stress by self-punishment. Second, the story shows the long interpersonal history behind Sooty's self-criticism, something the learning and cognitive therapists could not do because they don't collect information about childhood. Thirdly, the fairy tale fits nicely with Karen Horney's theories about hostility turning inward and resulting in neurotic needs (too high expectations or too critical a view so that one is never satisfied). Also, the story illustrates psychoanalytic repression of violent emotions which can be uncovered with insight and removed by expressing the emotion, called catharsis.

Finally, the tale has a Transactional Analysis (see chapter 9) theme. Sooty started with a "I'm OK; You're OK, Mother" attitude. That changed to "I'm not OK; You're OK" when she adopted her mother's views and became self-critical. Then to "I'm not OK and neither is anyone else." Later, when the prince's insight enabled her to see how the old queen's need to put her down had led to her hating herself, she started to hate her mother: "I'm OK; You're not OK, Mother." Eventually, to break the spell (of irrational, ain't-it-awful thinking), Sooty had to understand and accept that both she and her mother behaved "lawfully," i.e. there had to be reasons for the old queen's put downs, cynicism, and unhappiness (maybe the queen's mother was critical, maybe Sarah was prettier and smarter and a real threat to the queen, maybe...). By accepting and understanding herself, her mother, the past, and all human beings, Sooty Sarah was

freed from irrational thinking and could now become her highest potential--an accepting, happy, beautiful princess.

Guilt

Depression-prone people are super aware of their wrong doings--and feel especially guilty. Mowrer, et al (1975) does not believe this guilt necessarily involves some highly immoral behavior, such as intense hostility or vile impulses, but rather could be the accumulation of many ordinary "sins." We all do inconsiderate things: selfish acts, hurtful comments, just not thinking of others, etc. Our society encourages us to look out for #1 first or "do your own thing." As Mowrer observes, since the Protestants protested confessing to a priest 500 years ago, the Protestant religions provide no authorized way to confess our sins and atone. And, because we hold inside "real guilt" for what we have done, we become depressed and may have other neurotic reactions. (Other theorists say it isn't guilt as much as being ashamed of not trying harder.) Mowrer's solution was to form "integrity groups" (modeled after the small early Christian congregations) in which understanding, permanent friends listened to our shortcomings (our "sins"), forgave us, and then helped us make up for the harm we have done.



Regret for things we did can be tempered by time; it is regret for the things we did not do that is inconsolable.
-Sydney J. Harris



Guilt isn't always the result of *doing* something inconsiderate or immoral. Often it is just not doing what you think you should--"I should never have let my son go out with that crowd," "I should have known they weren't telling me the truth," "I should have kept better records for taxes." In this case, you may be assuming too much responsibility for whatever happened, setting impossible (perfectionistic) standards, and/or engaging in irrational thinking (see #6 and #7 above). Your mistaken views of the world and your unreasonable expectations of yourself may cause guilt. Guilt may cause depression. Or there is another possibility: whoever makes us feel guilty is resented. In the case of guilt or regrets, you make yourself feel badly; thus, you become angry at yourself, and that anger is assumed by analysts to be the cause of depression. Handling guilt and regrets is dealt with in the next section.

Unmet dependency

Some psychoanalysts and interpersonal therapists have looked into the history of depressives and found over-protective, indulging, overly involved or over-controlling, restrictive parents. The child grows up with an "oral character:" dependent, low frustration tolerance, and so

desperate to have people like them that they are submissive, manipulative, demanding and so on. Before becoming depressed they are described by therapists as "love addicts in a perpetual state of greediness...sending out a despairing cry for love" (Chodoff, 1974). Their self-esteem depends on the approval of others. When their dependency needs are not met, they become depressed and cry, just as they did as infants.

Moreover, it usually makes us mad when we feel weak and dependent. So, an over-dependent depressed person may resist help ("You can't make me be productive and happy") and become hostile ("I will pay you back for not loving me"). Thus, the loss of love is a triple threat to a dependent person prone to depression: (a) sadness and panic occur because our vital, life-long struggle for security has been lost, (b) low self-esteem and hopelessness occur because "I have lost everything" or "I do not deserve anything" and (c) anger and resentment occur because "they have deserted me, a helpless child" (Zaiden, 1982). So, it isn't surprising that research confirms, especially for very needy people, the old saying, "you can't live with them; you can't live without them." Relationships (marital problems and stress with children) are the most common stresses associated with depression in women. And, relationships (good, caring, intimate ones) are the best protection against depression (Brown & Harris, 1978; Klerman & Weissman, 1982). See sections below on loss of a relationship and loneliness.

These interpersonal, psychodynamic, and psychoanalytic therapists would say that explaining depression as a result of negative thoughts or a lack of social skills is superficial and foolishly ignores the life-long, internal struggle for love for survival. Likewise, this theory sounds very similar to the currently popular feminists' description of social pressures put on traditional women to give up their individuality ("be nice," serve and accommodate others, put your needs last) in order to be "loved." Evidence is accumulating for this kind of theory (Barnett & Gotlib, 1988), including relying on others for one's self-esteem (see chapter 8).

Impossible goals or no goals

Overly demanding parents who are critical, perfectionistic, and harshly punitive tend to have anxious, withdrawn, and sometimes hostile children who have an "I'm not OK" attitude (like Sooty Sarah). Perhaps they adopted the parents' impossible goals. On the other hand, Coopersmith's (1967) work suggests that uninvolved parents, who do not discipline consistently and/or do not provide moral guidelines for living, tend to have children with low self-esteem (and higher risk of depression).

Losing one's goal or values may lead to depression too. Hirsch and Keniston (1970) studied 31 drop outs from Yale during the late 1960's--during the time of the drug counter-culture, hippies, flower people, anti-war demonstrations, etc. They did not flunk out; they just weren't

interested. Indeed, nothing interested them very much. They seemed mildly depressed. But there had been no losses, no big stresses. Yet, one experience was common: loss of respect for their fathers. They had once idolized their fathers, but now could not accept their fathers' values. Middle-class materialism, money, and the country club weren't for them. They felt lost, unsure of what they wanted, and a little bored with it all. Thousands dropped out of school and traditional society during the 1960's and early 70's. This condition has been called "existential neurosis." Existential therapy aims to restore the person's sense of freedom and responsibility for his/her choices now and in the future. To do this, life must have meaning and purpose. (Note: the dropping out stopped in 1973-74 when we had a recession causing people to start worrying about making a living. The drop outs would be 45 to 50 years old now and have 20-year-old children.)

Shame: feeling ashamed of yourself has to be depressing

A critical problem with several previous theories is that the origin of the depression is not clear, i.e. where exactly does the helplessness, the negative views, the irrational ideas, the faulty thinking, the self-criticism, the low self-esteem, etc., come from? The shame theory can not be faulted in this way; it identifies the origin as early childhood experiences. Shame is feeling you are inadequate, inferior, lacking, not good enough, "ashamed of myself." In contrast with fear which involves external threats, shame is when we feel disappointed about something inside us, our basic nature. Shame is an inner torment: feeling cowardice, stupid, unloved, worthless, "a bad person." We hide in shame, i.e. we "hang," turn, or cover our heads, we lower our eyes, we isolate ourselves. (There is a related dimension--shyness or bashfulness--but here we are dealing with self-loathing or feeling ashamed of oneself.)

The great concern with addictions in the last 15-20 years has resulted in a new body of literature about the dysfunctional family, toxic parents, the inner child, codependency, adult children of alcoholics, support groups, etc. There are 100's of relevant books: Kaufman (1989, 1992), Bradshaw (1988, 1989), and Beattie (1989).

The origin of shame is usually assumed to be in our infancy or childhood. Shaming is used for control by parents, by friends, by society. Some of the most hurtful discipline consists of shaming comments: "shame on you," "you embarrass me," "you really disappoint me when...." We say insulting things to children that we would never say to an adult: "stupid," "clumsy," "selfish," "sissy," "fatty," "it's all your fault," "you're terrible," "you're hateful," "stuck up," etc. Many adults vividly remember the sting of these comments. Siblings and peers are cruel: mocking, laughing at, teasing, calling names, etc. Children are slapped and whipped, overpowered and humiliated, their "will" broken. All of this may make a child feel ashamed (depressed) of him/herself.

Even in adolescence we feel watched and judged (mistrusted); we are "shamed into" giving up crying and touching; we are looked down upon if we aren't successful, attractive, independent, and popular. We feel ashamed if we are poor and dress poorly, if we are over or under weight, if we can't express ourselves well or use poor grammar, if our grades are low, if we have few friends, etc. Some shame and anxiety may serve useful purposes, but it can be devastating.

There is some data to support the shame-based theories. Andrews (1995) found that "deep shame," not just dissatisfaction, in women about their bodies (usually breasts, buttocks, stomach or legs) was powerfully related to suffering severe depression. If a female is physically or sexually abused as a child or as an adult, it increases the likelihood of depression four or five times! Only childhood abuse caused shame about the body in women, however. See Lisak (1995) for an impactful discussion of the effects of childhood abuse on males.

The memories of our past--our childhood and adolescence--form our identity or our basic sense of self. Because we have shame-based families and cultures, shame gets connected with many things, such as our basic drives, interpersonal needs, feelings, and life purposes. Examples: much shame is attached to sexual drives (witness the uneasiness we feel about masturbation, not to mention homosexuality) and to hunger drives (witness the feeding problems of infants, the fights over food with children, and the eating disorders of young people). We are deeply hurt and made ashamed of our needs for closeness and security whenever a basic bond is broken by rejection, abuse, neglect, divorce, or smothering overprotection and overcontrol. Sometimes shame is connected with our bodies, our lack of competence, our life goals (witness others' reaction to someone wanting to be a popular singer or a girl wanting to be a mechanic or a boy wanting to be a nurse). Also, emotion-shame connections ("Don't cry!" or "Don't feel that way!" or "Stop sniffing or I'll spank you") are made and we become ashamed of crying, anger, fear, self-centeredness, even joy sometimes. And, in extreme cases, you can become ashamed of everything you are--of your entire self--"I am worthless." Shame is a powerful force but we can understand and overcome some of its sources.

There seem to be several natural defenses used against self-attacking shame:

- Striking out at others. Attacking others by being critical, sarcastic, or abusive are ways to repair a wounded ego and to protect our vulnerable weak parts from exposure. Acting superior and having contempt for others are other ways to sooth a hurting self.
- Striving for power and being perfect. The wish of a child would be to make up for our weaknesses by becoming powerful and being perfect.
- Blaming others. What better way to deny our weaknesses than to blame others for our problems or for the world's problems?

- Being an overly nice people-pleaser or rescuer or self-sacrificing martyr. If you feel unworthy, your hope might be to compensate for it by being "real good." Being super nice often means pretending or lying about our feelings and true opinions, presumably because we are ashamed of our real selves.
- The self can withdraw so deeply or shut off the outside world so completely (denial) that shameful actions or events just don't upset our self, in this way the self can't be hurt.

Obviously, a person feeling shame but using these defenses would inflict shame on others; that is, wounds of shame are passed from parent to child. This is done by parents in a variety of ways: (a) verbal, sexual and physical abuse, (b) physical and emotional abandonment (the child may even be expected to take care of the parent's emotional needs), (c) thinking of children as insignificant inferiors to be dominated and blamed *or* as persons to be controlled by threats of rage, disapproval, and withdrawal of love *or* as persons to be taken care of excessively, and not told the truth because they are needy, fragile, and "can't understand" *or* as persons to stay emotionally enmeshed with because they are perfect, wonderful, can meet your needs, and may be the only ones that care for us. So, shame begets shame.

What are the consequences of a shame-oriented family? Self-blame and criticism (like Sooty Sarah). Constantly comparing yourself with others and coming up short. Depression--we may dislike and disown parts of our self and even feel disdain for our self as a whole. The shamed person may engage in compulsive disorders--physical and sexual abuse, drug and alcohol addiction, anorexia-bulimia and obesity, workaholism, sex addictions, addictions to certain feelings (rage, being shamed and rejected), intellectualization, anti-social acting out, and other personality problems, including multiple personality. The list is long. Some of these "sick" behaviors, like addictions, help us hide our shame; some, like workaholism, try to make up for our weaknesses; some, like abuse, adopt the harmful behavior that was imposed on us; some, like criminal acts, reflect fear and hatred of the shaming techniques used against us. Shame operates inside all of us...it is a voice inside our head. The voice usually sounds like our parent. Sometimes the voice of shame is healthy and helpful; sometimes it is unhealthy and self-defeating. Nathanson (1995) should help you understand this complex emotion.

Shame-based families often have unspoken but well understood "rules," such as: Don't have feelings or, at least, don't talk about them. Don't try to make things better--leave the family problems alone. Don't be who you really are; don't be frank and explicit; always manipulate others and pretend to be something different, such as something good, unselfish, and in control. Always take care of others, don't be selfish and upset others, and don't have fun. Don't get close to people, they won't like you if they know the truth. Rules such as this keep you weak, hopeless, immature, hurting, and unhealthy--depressed and maybe addicted as well.


 Discouragement is simply the despair of wounded self-love.
 -Francois De Fenelon



Treatment, according to this theory, involves uncovering the sources of shame and recognizing the oppressing controls placed on you by internal voices of shame, family rules, and cultural-gender restrictions. Getting free may mean taking care of the hurt, scared little boy/girl inside, and building your self-esteem (see the later section on shame in this chapter and method #1 in chapter 14).

Lacking self-control causes depression

This explains why single women with little education and low income are the most likely to be depressed; they lack support and control over their lives. Also, dominated women report feeling they have "lost themselves." They are in a relationship in which they have lost the option of expressing their feelings openly, lost faith in their own ideas, lost reliance on their abilities and skills, lost their self-respect, and even lost their right to express anguish and despair (Jack, 1991). One can see why they must suppress their very being to keep their last shred of "love." Somehow these suppressed parts of our inner self must regain some control and learn to express themselves again.

Rehm (1977) said the lack of self-help skills, i.e. not knowing how to get better, caused depressed people to over-emphasize the negative, set too high standards, and give too little self-reinforcement. Pyszczynski & Greenberg (1987) contended that depression is the inability to avoid focusing on one's self. D'Zurilla & Nezu (1982) claimed that poor interpersonal problem-solving skills cause depression; the skills depressed people often lack are (a) the ability to see alternative solutions, (b) the ability to develop detailed plans for reaching a final goal, and (c) the ability to make decisions. A sense of self-control is basic to these three skills. This way of viewing depression expands beyond the helplessness theory, which focuses on a pessimistic attitude; it *emphasizes the importance of skills and cognitive techniques*, which increase our ways and means of self-control as well as our optimism.

This "explanation" of depression says much more than "take responsibility and heal thyself." To all of us, whether we are now depressed or not, it says that more research must be done. Miserable people can't learn what they need to know if wise people and science haven't uncovered the knowledge yet. It is a scientific necessity to laboriously test the effectiveness of each promising anti-depressive self-help method. There is already considerable evidence that some self-control methods work, but there are thousands of ordinary, everyday methods still to be tested with many different kinds of

depressed people (maybe 100 years of research--let's get going!). Consider these complexities which need to be clarified: married people have more support, thus, less depression. Okay, but *if* women have more support than men, why are they more depressed? (See discussion of gender differences above and in chapter 9.) Moreover, we ordinarily think support is gotten by talking to someone, but Ross & Mirowsky (1989) reported that talking *increased* depression. How could this be? Perhaps talking (without problem-solving) drives others away and/or involves self-handicapping more than garnering support. For instance, research has shown that depressed people more than nondepressed people will actually fail a task (then talk about how awful they feel) in order to avoid doing more of a simple task (Weary and Williams, 1990). Like the motivated underachiever in chapter 4, some depressed people seem motivated to do poorly, have little self-control, and be depressed; depression may sometimes provide convenient excuses to ourselves and to others.

This last explanation of depression emphasizes how uninformed the depressed person is about self-control and how much more science needs to learn about what helps and what harms depression.

Summary of the Causes of Depression and How to Use Them

These 14 theories give you ideas about how depression develops. Each theorist tends to assume that his/her explanation is *the* major cause. But, as you know, I don't think life is simple. I suspect that any one person's depression may have many causes. For instance, you might have a genetic propensity for depression. Then, you grew up in a shaming family who had a critical, pessimistic attitude. Feeling rejected anyway, you sensed and resented the hostility within the family, which led to your gaining a lot of weight at puberty. All these factors together resulted in your having serious social problems and low self-esteem; you not only disliked yourself, you felt your family had caused a lot of your emotional problems--and told them so. The family had never been emotionally supportive anyway and honestly thought "if you are fat, stop eating" and "if you are unhappy, get happy--and drop all this psychology crap about parents being responsible." Being unable to deal with these personal problems, when your lover of two years, who you depended on greatly, decided to dump you, the depression was more than you could handle. You become lonely and sad all day, nothing seems fun any more, you gain more weight, feel tired and listless, become more self-critical and guilt-ridden, are unable to see anything good in your life now or in the future, and even have some thoughts of ending it all if your lover doesn't come back. The history is complex. You have serious depression and need professional help; it is too late to depend on will power alone. Yet, you must also learn about and help yourself. That's real life.

You need to understand and consider how true each theory is of you--perhaps you need to read more or talk it through with a relative, friend, or counselor. Clearly, understanding the possible causes (in

your case) helps you work out a possible solution. Consider the five parts or levels of any problem--behavior, emotions, skills, cognition, and unconscious factors--and then plan your attack, based on the rest of this chapter and chapters 11-15. Keep trying to climb out of the darkness until you feel better. Even if the depression is mild to moderate, get help if your self-help efforts don't work within a month or two. There are medications that relieve many people's depression; don't be foolish and reject drugs if psychological approaches don't work. Keep your hopes up.

Sad Times in Our Lives

There are specific situations that especially depress us (see the index at the beginning of the chapter). Understanding those times and knowing some of the available resources can be helpful. Of necessity, the coverage of these topics will be brief, but there are valuable references listed here.

Death

All of us must die. If you have a long life, you will experience the death of your grandparents, your mother, your father, your aunts and uncles, your spouse, most of your friends, your brothers and sisters, and maybe some of your children. These may be the saddest times of your life. Death is, however, an experience most of us avoid thinking about as much as possible. No matter if we believe in an afterlife or not, almost all of us fear and dread death. No matter if we are miserable and our condition hopeless, most of us want to postpone death until the last possible moment. But this isn't always true; indeed, some of us invite death (see next section).

Death involves intense emotions. Elisabeth Kubler-Ross (1975), a psychiatrist, has helped us understand the experience of our own death. She describes five common stages: (1) shock and denial, "no, not me," (2) anger, "damn it, why me?", (3) bargaining, "okay, but first...", (4) depression, "I'll lose so much," and (5) acceptance, "I'm not happy about it but it's time to go." We have different death-styles: a few of us realistically accept it, others deny it. Some feel helpless and just submit, a few seek death to avoid suffering. Some can serenely transcend death, others defy it and go out fighting (Bernstein, 1977). Understanding the stages and diversity in death may help, but the best advice I've heard is Leo Buscaglia's: "live your life so you won't die alone."



The clock of life is wound but once,
And no man has the power

To tell just when the hands will stop,
on what day or what hour.

Now is the only time you have,
So live it with a will.
Don't wait until tomorrow,
The hands may then be still.
-Author unknown



The most painful emotional trauma in life is the death of a loved one. Our society denies the seriousness of death; we sometimes think the grieving person should "get over it" and be back at work in a couple of weeks. The truth is the sadness lasts for years, flaring up on special occasions and anniversaries. One in six of us lose a parent before we are eighteen (Bernstein, 1977); such people have a 35%-40% chance of becoming depressed later in life. At the time of death, it may be even sadder when the dying person is young and has not gotten to finish living his/her life. But, in general, the closer we were to the deceased, the longer the grieving takes. There is a saying, "When your parent dies, you lose a part of yesterday. When your child dies, you lose a lot of tomorrow."

Facing a loved one's death is not only hard; it is complex. St. Augustine observed that grief is a mixture of sorrow and joy--joy that one is still alive and had shared one's life with the deceased and sorrow to have one's life diminished by the loss of the loved one (Grollman, 1974a). Lots of other feelings may be involved too: shock, denial of the death or obsessed with it, anger towards others even the deceased, self-criticism and guilt, abandonment, vulnerability, fatigue, confusion, embarrassment, difficulty talking to others, fear of going crazy (things may seem unreal and it isn't uncommon to think one has seen or heard the deceased), dread of our own death, relief in some ways, and so on. A grieving person may also have many of the symptoms of depression mentioned early in this chapter. These feelings are normal, but they must be "worked through."

We never really "get over" a death of a loved one. Indeed, about 25% of widows are still seriously depressed one year later. Even with a good adjustment, it is normal to feel a wave of sadness engulf us occasionally, e.g. when we see something that belonged to the deceased or on a holiday. We do get to the point that sadness doesn't overwhelm us and we carry on with our lives.

This "working through" of grief takes several weeks for some and months for others. One has to build a new reality, a new life. Experts suggest that you start by accepting reality--that the person is dead and never coming back. *Express your grief* if you can, avoid drugs, and avoid "throwing yourself into work," although keeping busy is a good idea. The Bible says, "Weep with those who weep." This is your grief work. Share your memories, good and bad. For some, however, it will be easier to remember and release their feelings alone. Get back

into a routine. Break your ties and dependency on the deceased. Cultivate new interests. Recognize that time heals. Read some sensitive and useful books (Rando, 1991; Bernstein, 1977; Grollman, 1974b; LeShan, 1976; Lifton & Olson, 1975; Shepard, 1976; Colgrove, Bloomfield & McWilliams, 1991). For a comprehensive coverage of many aspects of grieving, I recommend Fitzgerald (1994). Try to become active (unemployed widows had more difficulty overcoming depression than anyone else).

What kinds of losses are hardest to handle? A sudden, unexpected death is usually harder to accept than an anticipated death for which we have had time to prepare. A highly rated recent book by Noel & Blair (2000), *I Wasn't Ready to Say Goodbye*, might be especially helpful in this situation. The death of a person with whom we had an intense but mixed relationship is often harder to handle, e.g. a loved one who was both loving and inconsiderate, hurtful, untrustworthy, selfish, etc. Or, perhaps you feel guilty because you were distant or unkind to them. In any case, having "unfinished emotional business" greatly complicates the grieving process. Also, the death of a person on whom we have enormous dependency is difficult to handle, especially if that dependency left us without a life of our own and incompetent to care for ourselves. Lastly, the effectiveness of our personal support system--family and friends--is an important factor in recovery from a death. Support for certain losses are likely to be especially weak: when we live away from family or have few friends; when the relationship is "secret" or "silent," such as a divorced spouse, a gay lover, a long-term affair, or a close co-worker; when the loss is an unborn or a just born baby; when the grief-stricken person is a child and "protected" from reality (Kleinke, 1991).



Go get counseling if months later
 you are sleeping and eating poorly, socially withdrawn, or feel ill, or
 you have shed no tears or can't talk about the deceased, or
 you have an undiminishing sense of loss and continuing lack of purpose, or
 you are unhappy, think of killing yourself, can't concentrate or work, or
 you can't get rid of the resentment or the guilt about the deceased, or
 you are very frightened, behaving oddly, or fighting with relatives or friends.



A few cultures *accept* death as part of life; many *defy* death by believing in "everlasting life;" others *deny* death by refusing to consider what dying is really like. Nuland (1994) sensitively helps us realistically confront the many physical processes of dying. On a spiritual level, enormous effort is invested by our society in convincing people of an afterlife and that death has great meaning. I hope they are right but suspect that death simply means it's the end of another life which was of great importance to the dying person, to his/her offspring, and, hopefully, to a few other people as well. When a person permits him/herself to believe that he/she may have only one life to live (and not eternity), it changes his/her plans. Our society has not

thought that out very well; it's too busy denying and defying. For the moment, that's apparently the best we can do. Regardless of what we think happens after death, we should assure that every life ends with dignity and honor in recognition of a significant life.

There are many self-help books in this area, even though research-wise we don't know a lot about coping with death. There are even self-help books for the dying (White, 1980; Huntley, 1991, for children), for people trying to understand death (Kramer & Kramer, 1994), for people wanting to die with dignity (Weenolsen, 1996), and for persons with terminal illness wanting to die quickly (Humphry, 1991). Warning: Some people with depression and no terminal illness have killed themselves in ways described in the latter book. Depression can be relieved; no depressed person should kill themselves without first trying extensive medical *and* psychological treatment. Mental Health professionals denounce Humphry's book also because it seems to neglect the consequences to relatives of a suicide. There are also books for the survivors (Caplan & Lang, 1995; Stearns, 1993; James & Cherry, 1989; Staudacher, 1987), including specifically widows (Caine, 1990), young children (Palmer, 1994; Goldman, 2000; Dougy Center Staff, 1999; Johnson & Johnson, 1998; Worden, 1996; Kroen, 1996; Buscaglia, 1983—age 4-8; Moser, 1998—age 4-8; Romain, 1999—age 5-10), and adults who lose a parent (LeShan, 1988), and for consoling the survivors (Zunin & Zunin, 1991). The death of a child is especially hard to handle, so see Donnelly (1982) and DeFrain, Ernst, Jakob & Taylor (1991). For those struggling with why God burdened them with a death, read Kushner (1981) who denies God's omnipotence in order to affirm that God is good and will help humans find the strength to bear great losses. Grief following a suicide is also very difficult to handle (see Neff & Pfeffer, 1990). Other books to aid the grieving are cited above.



Children and Grief

I have remembered very few stories for many years, but this one I have remembered and still cry when I think of it. I have no idea where I read the story, possibly in Readers Digest. Many people believe that children don't know how to relate to a grieving person or how to handle death. This is sometimes true, sometimes it isn't.

Two four-year-old girls, Betsy and Lori, were next-door neighbors and the best of friends. They loved to play on the sidewalk in front of their homes. They were careful to avoid the street. But, one hot summer day, Lori was playing alone and for some reason ran between the parked cars. She was hit by a car and instantly killed. Of course, it devastated Lori's family but everyone on the block, who knew the girls and had watched them play so well together, was deeply upset. The neighbors sensed the grief that filled Lori's house but they didn't know what to do, except attend the funeral and express their condolences as

best they could. Betsy's parents had carefully told her to not bother Lori's parents because they were very, very sad right now.

The day after the accident, Betsy's parents realized that she wasn't in the house, so they went outside and called for her. Soon, she came out of Lori's house. Betsy's parents were irritated that she had gone to Lori's house, although both girls were permitted to go into each other's house at any time. They asked, "What were you doing at Lori's house?" "I was helping Lori's Mom," Betsy said. "How could you possibly help her," they demanded. "I climbed into her lap and cried with her," said Betsy...



Home health care and support groups may be especially helpful during a time of deteriorating health and grief. For home care, I recommend Deborah Duda's (1987) *Coming Home: A Guide to Dying at Home with Dignity*. For hospice care of adults, write The National Hospice Organization, 1901 N. Moore St., Suite 901, Arlington, VA or call 1-800-658-8898 or 1-703-243-5900. [Hospice Webb](http://www.hospiceweb.com/) (<http://www.hospiceweb.com/>) provides information and helps you locate services in your area. For hospice care of children, write Children's Hospice International, 700 Princess St., Alexander, VA 22314 or call 1-703-684-0330. For self-help groups dealing with a loss of a child, write The Compassionate Friends, P.O. Box 3696, Oak Brook, IL 60522-3696 or phone 708-990-0010. For groups dealing with the loss of a spouse, write THEOS, 1301 Clark Building, 717 Liberty Avenue, Pittsburgh, PA 15222-3510 or call 412-571-7779.

Suicide

Are you having thoughts of suicide right now?

Are you feeling really down? Do things seem hopeless? Have you thought of killing yourself as a way out? Do thoughts of suicide keep bearing on your mind? Have you thought of a specific suicide plan? Have you started to find some means of carrying out the plan? Have you tried to kill yourself before?

If you are not suicidal now, feel free to skip down a page to "A powerful argument against suicide."

If you are answering some of these questions "yes," your situation could be serious and I want to get one main message across to you: Please get help with your problems. Why is that my immediate goal? First, because some people kill themselves impulsively, taking only a few minutes between having the idea and acting on it. Please don't be one of those people. Second, your answers already indicate difficult personal/emotional problems. It will probably take time and new

attitudes or skills to solve these problems. So, think seriously about [finding professional help](http://psychologicalselfhelp.org/Chapter2/chap2_44.html)

(http://psychologicalselfhelp.org/Chapter2/chap2_44.html).

Considering the possible severity of the problem, there are no good reasons to avoid such help. Help is almost certainly available! Third, you are hardly in mental or emotional condition to make life-or-death decisions. You need help finding other options. Fourth, and most importantly, suicide is a *permanent* solution—you can't take it back—for what is almost always a *temporary* problem or situation. Please get help to develop the best possible solution to the bad situation you are in.

How can you find a serious, helpful person to talk to you right away? The answer to that may be a bit complex.

If your urge to hurt yourself is very strong, possibly deadly, and pressing now, you really need to contact emergency health care responders immediately, so call 911. If you are bleeding, sick, or have taken an overdose of pills, call 911 or have someone take you to the nearest hospital ER. If you have a gun or other weapon, call 911 or the police. If you are very confused and unable to concentrate or make sense when you talk, call 911 or call a local Mental Health Crisis Service or a Suicide Prevention Center (1-800-SUICIDE or 1-800-999-9999). The hospital Emergency Room, if they aren't overwhelmed, will examine you, let you rest, have a doctor, social worker, or nurse talk to you about your troubles and about getting continuing help, and perhaps give you some medicine to temporarily calm you down, if you want it. Many Community Mental Health Centers provide a 24/7 mobile crisis service.

If you are not in immediate physical danger but are feeling really down and need to have someone to talk to right now in the middle of the night (or day), call your therapist if you have one or have ever had one...or call a parent, a relative, a caring friend whom you know will be responsible...or call a Suicide Prevention Service (1-800-SUICIDE or 1-800-999-9999). Any of these people will talk to you immediately, help you calm down, and assist you to make plans for finding the long-term help you need. Many Suicide Prevention Counselors are only available by phone but they are familiar with your community resources and the Community Mental Health Center which has counselors available during the day.

If you are not in that much trouble and can wait until tomorrow to talk about your problems, I'd strongly recommend that you vow right now to give priority to finding a therapist tomorrow. Don't deceive yourself by saying "I'll just talk to a friend...Maybe I'll feel better after I think this through...my Mom will tell me what to do...I don't need a therapist; they couldn't help me anyway." Considering your answers to the questions above, you have the kinds of problems that probably can not be solved quickly and are best dealt with by talking regularly for several weeks with a professional. Your situation should not become a burden on a caring friend who does not have the time or the special

knowledge to deal with these particularly difficult problems. I discuss the importance of finding a therapist in several places in this book. If you haven't tried therapy before, the idea can be a little scary at first, but you will quickly discover how easy and reassuring it is. Therapists know what they are doing. They care. Getting help is vitally important. When the situation is very serious, preventing suicide is certainly *not* a self-help project!

As you work your way through your thoughts of suicide and get help, you will see that it would be very helpful to understand suicide better, especially the conditions and emotions that lead to depression, self-criticism, hopelessness, anger, conflicts and disappointments with others. This entire chapter deals with aspects of depression, negativity, pessimism, and self-blame, which are closely related to suicide. Explore the rest of the chapter, even the happiness topics, when you have finished this section.

A powerful argument against suicide

Life can be hell in the distraught mind of a person trying to resolve the complex, confusing and fierce arguments between the advantages and disadvantages of living and dying. In a time of unbearably painful hurt, stress, and misery, one can understand the appeal of quiet, peaceful oblivion. However, there is a downside to dying. Those consequences may not be clear to you without careful, objective thought about the future. Here is one simple study that makes the point I want every suicidal person to think about:

A famous study was done of people prevented from jumping off the Golden Gate Bridge between 1937 and 1971 (Seiden, 1978). The bridge has been associated with more suicides than probably any other structure. Between 1937 and 1978, 625 people are known to have died of suicide there, perhaps another 200 possible deaths may have occurred unseen at night or in bad weather. Dr. Seiden carefully followed the 515 "attempters" who were restrained from leaping off the bridge, and found that 94% were still alive an average of 26 years later or had died from natural causes. The follow up also found that these persons were slightly but significantly more prone (compared to the general public) to die violently, i.e., in accidents, homicides, or suicides, *but* these deaths were often within 6 months of the almost terminal experience on the bridge. Two important points: (1) If a person who feels like killing him/herself can be stopped, the chances are good that they will live a long and satisfying life. If you chose to end your life by suicide, you may be overlooking all the good that might happen in the rest of your life—the good feelings you would have and the good you could do for others, including the gift of life to all your possible descendants. Think about it. (2) Of course suicidal people should be given psychological help immediately and supported closely and carefully for at least six months; they shouldn't be left to handle these strong emotions on their own. Local Mental Health Centers and health insurance companies have this responsibility.

Since the desire to die, no matter how intense at the moment, is temporary in almost all circumstances, I strongly argue against the notion that "suicide is a person's choice at any time." I believe the considerate and loving thing to do is to *prevent* the suicide in any way possible, to provide optimal psychological help, and to encourage support and understanding from family, friends, and co-workers. Let's all urge the suicidal person to "hold on" and avoid using their fatal final solution for what is likely to be a temporary problem (Quinnett, 1987, 1992). In no way is this attitude being overly optimistic. It is true that some people have depression that lasts for years. But the suicidal person has no way of knowing his/her depression or other problems will be interminable. The Seiden follow-up study gives hope...therapy offers hope...medication offers hope...self-help offers hope...relatives...friends...groups...offer hope. You can get better!

As a therapist that is the view I need to take. On the other hand, we can all recognize that death probably ends the intense personal pain another person is feeling. When that pain becomes unbearable and lasts...and when there is little or no hope of lessening the pain, one can understand the desire to die. A helper must listen with understanding and deep sympathy to their insoluble (to them) plight. The therapist's job is to help them find a way out of this dilemma.

Understanding Suicide

My purpose in this section is to give you some idea of the scope of the problem and the rates of suicide in different groups and conditions. Next, I'll give a brief summary of the many circumstances, traits, motives, and causes that might contribute to suicide. Several kinds and types of suicide will be described. Then a brief review of the efforts and measurement problems associated with predicting suicide, i.e., finding and accurately using the warning signs. Finally, we will briefly cover various ideas about how to prevent or reduce suicides and how therapy can help a suicidal person, as well as what self-help methods might serve you well.

As usual, near the end of this section I will link you to several Web sites and cite many books explaining suicide. Perhaps no other human act is as shocking, intriguing and mysterious. It is a serious topic that has been deeply explored by scholars, biographers, and researchers. The result is lots of information; yet, much is still not known. I will try to share with you the available advice for depressed people, and also for their survivors--relatives and friends, and for therapists and suicide counselors.

Just as every life is unique, every suicide is different, complexly caused, and profoundly sad

Somewhere between 10% and 50% of us, at some time, have thought of killing ourselves. We almost always look back on those times as being awful experiences but we think dying would have been a terrible mistake. Yet, more than 30,000 Americans every year

actually act in times of terrible stress and commit suicide, men three or four times as often as women. Over 200,000 in the US attempt to kill themselves each year, women three times as often as men. Men tend to use guns; women use drugs (70% of the time prescription drugs). Suicide occurs more among college students than among non-students, more among divorced than married, and more among physicians, lawyers, and dentists than other professionals.

The risk of suicide increases from ages 15 to 25. Also, amazing as it seems, the suicide rate in that age range has tripled in the last 30 years. We don't know exactly why. Today, only accidents and homicide kill more than suicide in these ages. A 1991 U.S. Center for Disease Control survey of high school students showed that 34% of girls and 21% of boys have considered suicide. Actually, *during 2001*, CDC found that 28% of high schoolers had felt sad or hopeless for a two week period, about 16% had made a "specific plan," and 8% "had tried suicide," resulting in 2% of them requiring medical assistance! That is appalling.

For teenagers their social environment can arouse intense emotions. If a 14-year-old girl has very few friends and/or feels socially rejected, she is twice as likely to have suicidal thoughts. It is also distressing to girls if their friends don't get along. That doesn't seem to be nearly as true for boys; keeping the same close friends may not be as crucial to boys. Most boys can blow off conflicts among their friends; they are less bothered if a buddy gets mad, doesn't like them, or disagrees with them. Girls need to be accepted by friends and to keep the group together (Moody & Bearman, 2004). So, girls who are alone or in the midst of emotional distress among friends may need help.

A safety net is needed. Teens of both genders have twice as many suicidal thoughts if they have known a friend or relative who has killed him/herself. Suicidal thoughts are also much more likely if they have homosexual feelings. Being sexually assaulted doubles the suicidal thoughts, at least for girls. Depressed adolescents using alcohol and drugs are 30% more likely to attempt suicide than nonusers (25% of the suicide attempters had made multiple attempts), and the attempters reported much more loneliness, alienation, rejection, and punishment during childhood. It is interesting that less than 1% of young people, who attempted suicide, called a suicide "hotline," one third of their parents never found out they made an attempt, and almost two thirds lived in a home where a gun or other lethal means was still available *after* attempting to kill themselves (Berman, 1990). Wow! Lots of accidents waiting to happen. How foolish can we parents be? At least lock up the guns securely.

The rate of suicide is also high in the elderly (Leenaars, et al, 1992). Of course, deciding how to deal with a painful, discouraging experience is strongly influenced by whether you potentially have 50-60 years to live or only 2-5. Our society is gradually re-thinking the morality of suicide ("calculated departure" or "dying with dignity")

when one is suffering near the end of life with little realistic expectation of future happiness or usefulness. That seems acceptable, maybe even healthy to me (See Quill, 1993). But where there is any hope, including through the use of therapy, medication, and strong pain-killers, suicide is just not a good option. At least, one should give talking treatment and drugs a try.

A major problem among the elderly is that depression is overlooked or neglected by the primary care physicians and families. Maybe old folks are expected to be unhappy; maybe doctors don't ask and they don't tell; maybe general physicians don't know how to ask or test for depression. Anyway, their sadness, lack of interest, and discouragement don't get treated correctly. A recent study reported in the March 3, 2004 issue of *Journal of the American Medical Association* took an innovative approach. Randomly older patients considered depressed were assigned to "routine care" or to a "special intervention" which involved a MA level "depression-care manager," and either SSRI medication or, if they didn't want to take pills, psychotherapy by the care manager. Their feelings of depression and frequency of suicidal thoughts were measured at 4 and at 8 months. Results: Psychotherapy provided the fastest and the most effective treatment of depression and suicidal thoughts. At 8 months, 70% of the elderly who had started with major depression and thoughts of suicide had lost those thoughts, compared to 44% of the "usual care" patients. The massive use of antidepressants in GP's offices may eventually drag psychologists and social workers into the general health care process.

Almost 80% of all suicidal persons have been depressed for weeks and, of those, 65% to 80% have "cried for help." Many have gone to see their family physician; others have hinted to friends. Most have mixed feelings about killing themselves. They certainly want to be less miserable. They definitely want a solution, but at the moment, they can't think of any other way out. Only an estimated 5% to 20% of attempters definitely or completely intend to die; yet, many are willing to run the risk of death. They sometimes yearn to be rescued and for life to get better. I once had a deeply depressed patient who took drug overdoses three or four different times but always just before our appointments, partly, I think, to see if I would save her. These cries for help are usually telling others they are terribly upset and hurting, that they need help, care and love. If you hear such cries (comments, hints, questions, and jokes included), take it very seriously, listen and show your concern, urge him/her to get professional help immediately. You don't have to solve all their problems; just a little help--a little relief from the pain--may save a life (Shneidman, 1985).

Suicide may result from an almost infinite number of causes and circumstances

A therapist may find some of these mental conditions and situations related to suicide: 1. Intolerable life situations: Life seems a total mess, faced with terrible losses or catastrophes, feeling

overwhelming guilt or shame, having untreatable and terminal illness, or suffering a momentary loss of reason in an overly-emotional or intoxicated state. 2. Existential reasoning: "It is better to die than to live in prison or in such miserable conditions," "People hate or despise me, I can't stand it," or "I'm on the edge of killing myself, so why not take a chance (like going over Niagara Falls) and see if some good things might happen," "Maybe they would treat me better if I tried to kill myself." 3. Characterological factors: An impulsive, highly emotional, high risk-taking personality, an immature person with mood swings and a history of poor and violent interpersonal relations. These actions may look unintentional or almost accidental, such as the person who thinks "I will not jump if just one person smiles at me as I walk to the bridge." 4. Cognitive causes (without psychosis): Some suicides seem intended to change things, including to reduce their pain and misery or to inflict self-punishment on themselves or to hurt, punish, and defeat someone else. Suicides may be an effort to resolve a conflict, to make a choice, or to force a change on others. Often ongoing hopeless despondency is filled with urges to self-injure, especially if the self-destructive thoughts are mixed with angry and destructive impulses directed towards others. 5. Serious psychotic illness: Persons with major depression, bipolar disorder, paranoid schizophrenia and other psychoses get out of contact with reality and rarely but sometimes make irrational decisions that can result in death or suicide. Major depression and bipolar disorders have high levels of suicidal ideation. About 10% to 12% of persons suffering schizophrenia also have suicidal thoughts and it is estimated that 25% to 50% of that 10-12% attempt suicide within the first one or two years of being struck by their highly destructive sickness.

An early and prolific researcher of suicide, E. S. Shneidman (1968), preferred to think of three types: (1) The results of thoughts, e.g., for a social-political-religious cause, because of chronic physical pain, because of inner turmoil and mental illness. Examples: When the Christian church was young, many poor and deprived believers killed themselves to pass quickly into heaven. The church fathers' solution 1500 years ago was to make suicide a sin. Cause of depression #9 above, anger turned inward, is another example of this type, but among suicides only 25% were known to be negative towards themselves (Sue, Sue, & Sue, 1981). (2) The results of interpersonal conflict. Self-destruction can be a way to strike back and cause guilt; it can be for some the only way to express their anger. Often these people need help in handling relationships; they need social-communication skills and better decision-making. For example, one study reported that 30% of all adolescent suicides were gay, lesbian, or bisexual youth. Our culture had, I assume, made them feel different, abnormal, and guilty or resentful of homophobia. (3) The results of "dropping out" of life and feeling alienated, isolated, and futile. These people might need a meaningful purpose (which is usually possible to find--see chapter 3). Obviously, there are many ways to get to suicide as an end. If one really wants to explore in depth the possible causes, refer to David Lester (1997), who cites a lot of

research, or even better, if one is concerned about bipolar disorders and wants some sound advice, see Kay Redfield Jamison (2000).

Other researchers describe two other basic kinds of suicide: direct, quick self-destruction and indirect, slow self-destruction. The first is when someone shoots him/herself or runs a car into a tree. The second is when someone self-destructs by being accident prone, refusing to get or follow treatment, abusing drugs or food, abusing his/her body, risking getting AIDS, etc. Most of these people deny they are killing themselves, and I agree that many factors other than death wishes are involved in over-eating, driving recklessly, neglecting to use a condom, etc. Unfortunately, some people even believe the ancient Arabian idea that destruction or death is necessary before re-building or getting a new life at a higher level.

Two more views of suicide

There are many explanations of suicide: some erudite psychosocial speculation of the clergy and psychologists and some puzzled wonderings by grieving friends and family. I'll share with you a sample of the wisdom of both. Both convey many insights.

First sample: In his reflection about the causes of the deaths by suicide of two friends on the same day in Ireland, Dr Sean Brady, the Archbishop of Armagh, singles out the "twin afflictions" of (1) despair and (2) presumption as the "enemy of hope". Despair because it eats away at hope, and presumption because it involves a sense of entitlement to wealth and status that encourages selfishness.

The Archbishop writes: "Essentially despair derives from a loss of hope. This despair is often accompanied by a crippling fear; a fear of the present and a blindness to the future. A sign of this fear is an inner emptiness which consumes and debilitates and manifests itself in destructive ways which would include the inability to make life-long commitments and to face long-term responsibilities. This in turn often results in a frantic attempt to escape pressing reality within an aggressive pursuit of pleasure, which temporarily distracts, but inevitably disappoints and further exacerbates an already precarious situation."

Presumption, he writes, is the other contemporary temptation against hope: "What is alarming though, in a society focused on material gain, is the accompanying over-confidence that wealth and status can bring with regard to the apparent certainty and comfort of one's own position. This disengagement from the reality of the plight of others can anaesthetize the conscience, creating an institutionalized self-centeredness and selfishness, which are sometimes unquestioningly promoted on principle, pushing individualism to new extremes." © [Irish Independent](http://www.unison.ie/irish_independent/) (http://www.unison.ie/irish_independent/).

The second example of trying to understand suicide is very different. On January 1, 2005, the LA Times writers, Rubin & Murillo, describe some of the events that preceded the suicide of a 15-year-old girl from a working-class

family who had had many conflicts, especially between Velia and her mother. For quite some time, Velia felt no one liked her. She thought "friends" were rejecting and telling stories about her. That sounds very simple but the history is quite complex and a jumble of strong, disruptive emotions that are hard to understand. It is true that she had clearly been bullied but she was no mousey doormat. At times she was angry, mean, picking fights with others and threatened teachers, and getting suspended from school several times. Other girls jumped her after school. She was not a good student, missing school often. Her siblings had their own troubles with the law. Her mood changed quickly and often, being sweet and then bitter.

There were plenty of reasons to believe that there was boiling turmoil inside Velia. But few tried to help. Her mother tried but it often led quickly to a verbal or even a physical fight. Anger management class didn't help (it is known that 60% of suicidal teens are violent toward others). She revealed to a teacher a note about suicide but when informed her mother said "she wouldn't do that" and the father didn't believe suicide was possible either. However, she was hospitalized for 10 days or so. School Counselors seeing her thought she had many psychological problems. Other girls continued to reject her and some challenged her to fight. Then a new boyfriend killed himself. A sister tried to get a suicide counselor at the school to see Velia. But she died first. It is fairly common, as in this case, that intense problems set the stage for suicide. Others who kill themselves are quiet, perhaps withdrawn, and show few signs of having emotional problems or of being agitated.

Barriers to getting treatment

You may be surprised in the next several pages to read how often suicide occurs, how often it is attempted, and how often it is thought about. In the course of living, the frequency of suicide may not seem high to you because many suicides are not publicly reported. Unless a well known person is involved or the suicide is dramatic, many deaths by this means are overlooked, covered up, or attributed to "unknown" or other causes and many attempts are simply described as "accidents." The news media concentrates on the police reports of homicides and violence or on fire reports so we are impressed with these causes of death. The media frequently do not report suicides, so it looks like there are fewer suicides than homicides (not true). Actually, suicide is the leading cause worldwide of death by *violent* means. It is more common than murder *and* dying in war combined. Of course, most people just don't talk about their suicidal thoughts. In uneducated circles, suicidal thoughts are sometimes felt to be weird, crazy ideas. Sort of a sick thing to do. Moreover, families are held responsible by many people for not preventing this terrible behavior, thus creating even more social stress and feelings of shame for the survivors.

Why do so many depressed people avoid getting help to deal with their suicidal thoughts? Why don't more people admit how sad they are feeling to friends and loved ones? Why don't more sad people get anti-depressive medicine and/or seek therapy? In large measure the answer seems to be because of the huge *social stigma against suicide*

(and/or against being mentally ill). In many cultures suicide is considered such a dark, aberrant, or unnatural act that religions may actually consider it a sin and, not too long ago, there were laws against suicide and attempted suicide. Even today laws harshly punish helping a loved one to die voluntarily, no matter how understandable it might be. Dr. Kevorkian still serves his 25 year sentence for helping a very sick patient who wanted to die. Our country until very recently would not honor our soldiers by putting their names on the Vietnam Memorial if they had killed themselves months or years later, even when they fought and were awarded for bravery in Vietnam, had been captured and tortured for several years, and then were shipped home still traumatized and without treatment. It is as if, for the military, suicide wipes out all of the good you have ever done. If the pain one feels is emotional or psychological, then society seems to feel it's your fault. (There may still be several Vietnam veterans deprived of the recognition of having their name put on the wall.)

It is this strong cultural disapproval and negative attitude about suicide (blame-the-victim-ideas?) that result in people feeling too ashamed to admit their psychological pain and ask for psychological help. People with breast, colon, or prostate cancer might prefer to not tell a lot of people about their health problem but it wouldn't be because they feel personally responsible for the condition and personally shamed by it. Ironically, the wide-spread negative emotional reactions to the idea of suicide may contribute to more deaths by suicide, because fewer people seek treatment. Our cultural attitudes need to be changed, not to the point that suicide is accepted but to the point that treatment is accepted. Suicide involves intense unhappiness and distress, feelings that deserve our sympathy. Hopeless and self-destructive thoughts are not shameful but conditions to be gently challenged and corrected, while we keep the person safe. Every one of us, including people as young as junior high, must learn to hear "cries (or hints) for help" and respond to them by, first, recognizing there are intense emotional troubles in the person's life and, then, helping them find help.

If you are feeling very down on yourself and thinking it might be better if you just didn't exist at all, your self-destructive thoughts need to be expressed clearly to anyone who will listen. Don't just hint that you are sort of depressed or "feeling a little down." Many people, even though they are listening, will deny or distort those hints. Or they may immediately try to reassure you that "you will feel better tomorrow," "I felt that way last year," "as soon as you make up with her/him, it will be all right again," which you know isn't true. Such comments are trying to help, but they cut off further discussion of your painful distress. You need to be very blunt; keep saying "I am terribly depressed, things seem awful," "I feel like ending it all," "I really need help," and "Please help me keep from killing myself, I don't want to die," until a parent, a doctor, a counselor, a friend, or someone hears you clearly and will boldly help you. Your next step should be to seek a "professional friend," perhaps at school or through your health insurance or your family doctor or a therapist at the local Community Mental Health Center. Remember that over 50% of young people who

try to kill themselves do not get any professional help—not even *after* their attempt. That is disgraceful. As a society we must change...be more sympathetic, even or especially towards loners, jerks, and weird people. They may need help the most. Getting professional help is crucial. However, sometimes even the professionals drop the ball. So, be sure the doctors do their jobs, too.

In one study, 43,000 patients admitted frequent thoughts of suicide on a Pre-intake Questionnaire. However, 57% of the professionals who read the intake records *missed or disregarded* the patient's reports of suicidal thoughts and concluded there was "no suicidal ideation." Over half the time clinicians missed blatant "warning signs." This may be another reason so many depressed people do not get treatment. Many general practitioners do not recommend needed psychiatric or psychological treatment. You do not need a doctor's referral to go see a psychiatrist or a psychologist (you do need a way to pay for it or go to the Community Mental Health Center). So, again, the patient will benefit from knowing what is recommended treatment. This study was done by G. S. Brown and E. R. Jones for the PacificCare Behavioral Health organization and reported in *Crisis* (May, 2003), a journal of crisis intervention and suicide prevention.

Of course, getting help from supportive and caring friends is very important too but, please, do not stop there. They surely are wonderful friends to listen and help but they are not trained therapists. Be especially careful to not latch on to a sympathetic friend for *all* the help you need. Helping a suicidal friend can be a terrible burden, especially if you are the only one they tell their troubles to. It could continue to be an enormous psychological load, perhaps for life, if the friend you are trying to help dies, in effect, in your care. Please don't turn this comment, if you are the helper, into an argument for avoiding helping a needy person or, if you are the helpee, for dealing with your pain all by yourself. You need the best psychological help you can get, including an evaluation for medication. You almost certainly need therapy in addition to medication. You also need good friends and a caring family.

Within our culture, we should make it top priority for everyone to seek expert help, when it is needed, with all kinds of mental health problems, not just suicidal depression. It is an unforgivable tragedy that an educated society lets so many people with suicidal thoughts avoid careful treatment—remember 30,000 die every year. Over 50% are untreated. We couldn't stop all the deaths but we could prevent many. Perhaps the emotional or stigma-generated barriers to getting help could be reduced (a) by providing many public services announcements openly urging depressed and disheartened people to seek effective professional help, (b) by documenting to the public the research showing that various treatment programs truly help people recover from serious depression as well as interpersonal problems and mental illness, (c) by helping the average person realize that there are likely to be complex physical, biochemical, psychological, situational, and genetic causes of depression and suicide which he/she is not

totally responsible for, (d) by helping people realize that good parents and healthy families have suicides and mental illness; having emotional problems doesn't mean the family is sick (although it may be), (e) by making it clear that suicidal feelings and urges, as well as angry reactions, are usually caused by temporary conditions that will eventually change, and (f) by funding the study and treatment of this terrible condition that costs us so much in so many ways. Compare the huge amount of research devoted to cancer and heart disease with the limited funds for studying suicide prevention, especially in adults. We just let depressed and suicidal patients go untreated. Would we just let heart disease or cancer patients go untreated? Although I focus on self-help, I urgently want to persuade a deeply sad person to take the reasonable step of seeking help. You have to live before you can build a better life through self-help.

Rate of suicide by special groups

The [Youth Risk Behavior Surveillance Data of 2001](http://www.cdc.gov/HealthyYouth/yrbs/index.htm) (<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>) found that between 15% and 20% of students reported seriously thinking about attempting suicide in the year before they were interviewed. That is 1 out of every 5 or 6 students! When asked if they had made specific plans, about 15% said yes. Surveys show that 8% to 10% of students had actually attempted suicide sometime during the last year, with over 2% of them needing medical care. A total of approximately 500,000 people in the US are taken every year to an ER following suicide attempts. There are about 25 attempts for every death by suicide.

One American kills him/herself every 18 minutes, totaling about 30,000 per year. The US death rate is 11.4 people per 100,000. That figure has remained fairly stable year after year. In one year, approximately 765,000 Americans will attempt to kill themselves (they don't all go to ER). That is a lot of misery. World-wide 815,000 people chose suicide in 2000. The World Health Organization (WHO) estimates that every year one in every 60 people has a loved one or friend die via suicide.

These huge numbers, however, are hard for most of us to mentally grasp and to understand the scope of the problem. Another way to think of it is to compare suicide with other forms of violent deaths. According to the World Health Organization (Oct., 2002), as mentioned in the discussion of stigma, there are as many or more suicides than the total of all other "violent deaths" reported on the local news, including homicides, lethal domestic and child abuse, and casualties of war. Every day you can, in this way, estimate how many suicides occurred that day but were not reported. Note: while the social stigma keeps people from admitting their suicidal thoughts and getting treatment, the fewer reports of suicide in the news has a helpful aspect, since a higher rate of reporting suicides results in an estimated 10% increase in the local frequency of suicide. Also, when the news stories are long or make a front page or lead story, and when the

stories are dramatized or described in a gory way, or romanticized (Romeo & Juliet), or the situation is glorified, the result is more suicides. See [American Foundation for Suicide Prevention](http://www.afsp.org/) (<http://www.afsp.org/>) (2001), Reporting on suicide: Recommendations for the Media.

Serious depression and suicide in children and teens

The commonness of depression in adults has been cited before—about 12% of women and 7% of men in America struggle with depression sometime during each year. We are getting a clearer view of how many young people also feel seriously depressed—about 2.5% of children and 8.3% (3 million!) of adolescents. The CDC 2001 survey also found that 28% of students had felt so sad or hopeless almost every day for two weeks in a row during the year that they stopped doing some of their usual activities. As a society, we are often unaware of or deny sadness in young people; we don't see the signs. Many parents don't even think children *can* have mental illness or be depressed; thus, another reason they don't get treatment. However, when a child or teenager kills him/herself, which 5000 do every year in the US, they suddenly get our attention. Only auto accidents and homicides kill more teenagers. More than 1000 young people in the US attempt to take their lives every day. WOW! Did you realize that? This is a very serious problem. Schools have given suicide some attention, but we need a national movement to increase our early recognition of hurting youth. As mentioned before, adolescents and children need to be taught and encouraged to tell friends, family, teachers, professionals, etc. that they are feeling down. And every teenager needs to be taught to take very seriously all disclosures of suicide intent; they need to be taught what to say and do when a friend hints that they are thinking about harming themselves. This is serious business.

The suicide rate for teens has increased three fold since 1960. This seems to be in spite of many more Suicide Prevention efforts in schools, more Community Mental Health resources available, better Mental Health coverage in the media and in schools, and supposedly more general psychological sophistication. What is going wrong here? For one thing, most people who kill themselves are suffering or, more likely, have suffered for many years from depression or some other mental illness. The rising suicide statistics may be an indictment of the entire Mental Health system in our country. Community Centers are not well funded, focus more on chronic psychosis and not on youth or young families, and they are not adequately staffed to treat all the emotional problems in millions of families without health insurance. The Community Mental Health Services were a great idea in the 1960's but the clinics have not been evaluated and supported. Mostly they were turned into crisis centers for the poor and the chronically mentally ill. Consequently, the Mental Health Centers have for several years not been appealing to the middle class, the youth, or the elderly.

Rate of suicide by special groups

One way to find out the circumstances that lead to suicide is to investigate the backgrounds of adolescents and young people who attempt suicide. This has been done (Johnson, et al, 2002). The history of people who have attempted suicide often includes abusive parenting and poor child-rearing conditions early in life (young mothers, poor living conditions, belligerent behavior or trouble-making in school) and difficulty getting along socially later in life. A mindful society should consider serious interpersonal problems in childhood or early teens as signals that this young person needs help with emotional control, communication skills, and should be followed up for antisocial behavior, psychological problems, and self-harm in the later teens or twenties.

A family history of suicide attempts is an ominous sign. The rate of suicide is twice as high in families with such a history as in families who have had no suicides (Runeson and Asberg, 2003). Combining several studies of twins, adopted children, and controls, there is evidence that suicidal tendencies may be genetically transmitted (Qin, 2003). A study of 21,168 suicides in Denmark also finds that mental illness and substance abuse in the family are factors associated with a risk of suicide (Qin, 2003). Overall, Qin interprets the data to mean that several family genes, as well as environmental factors, may affect the traits of aggressiveness and impulsiveness which are associated with suicide. How much influence does the family history and genes have on the risk of suicide? Experts estimate that 10% to 13% of suicides would be prevented if suicidal death and psychiatric illness in the family could have been avoided (by better mental health care). So, while your family history is a factor, don't make too much out of it; having a psychotic relative or a suicidal one does not mean you are doomed to an awful future. A bad family history simply means that early in life your family and you should routinely and seriously evaluate your emotional/psychological condition and get professional help to stay as psychologically healthy as you possibly can.

It has also been found that psychiatric patients who have both serious psychiatric disorders, such as depression or bipolar disorder, and significant personality disorders, such as passive-aggression or narcissism, made more suicidal attempts than patients with only one diagnosis. These dual diagnoses are called "comorbid diagnoses" and are, in general, associated with more depression, more aggression, more impulsiveness, lower self-esteem, poorer problem-solving skills, feeling less loved by their families, and having had more parental suicidal behavior (Hawton, K. et al, 2003).

Interesting findings about suicide

1. 29,350 Americans died by suicide in 2000. That is 1.7 times as many as homicides.
2. Four times (some say 3 times) as many males as females die from suicide. Females attempt suicide more than males but use less lethal methods.

3. Divorced and widowed men and women have a suicide rate twice as high as married men or women.
4. Western states, where there are more guns, have more suicides.
5. Teens & young adults, middle-aged men, and elderly men have the highest rates. The above data is mostly from [Suicide in the United States](http://www.cdc.gov/ncipc/factsheets/suifacts.htm) (<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>).
6. About 3,000,000 American youth ages 12 to 17 contemplated suicide in 2000, over a million of them (37%) actually tried (SAMHSA, 2002). Only one-third sought counseling.
7. Over 10% of all young women have tried to kill themselves. 40% of suicidal Canadian girls reported conflicts with parents about gender roles, such as rules about dating and future plans (Pinhas, 2002). White women commit suicide at three times the rate of Black women.
8. What group in the US has the highest rates of suicide? Some studies say white males over 65. The rate for white women over 65 is much lower. Having a gun in the house doubles the suicide rate and 71% of suicides at this older age involved a handgun (Conwell, 2002). On the other hand, the Center for Disease Control and Prevention reported in 2000 that men between 25 and 54 had the highest suicide rate. *Both* groups (men over 65 and men 25 to 54) have very high rates and neither has received much attention or prevention services.
9. 12% of urban gay or bisexual males have attempted suicide, which is 3 times the overall rate for males. Early suicidal attempts are often related to "coming out." 28% of older gays and 52% of younger homosexuals report being harassed.
10. Suicidal persons often report being self-blaming and in an unbearable mental state before acting but the actual suicide action may seem like a trance, feeling numb and no pain as they cut, and essentially dissociating themselves from the process (Baumeister, 1990). 25% of "almost lethal" suicide attempters spent less than 5 minutes making the decision to act...5% of the quick decision-makers reportedly took one second between decision and attempt (Simon, 2003). That is scary.
11. One large study found that psychotropics, anti-depressives, anti-OCD, and other medications did not lower suicide rates more than placebos (Dr. Khan, 2002). However, other researchers have claimed that anti-depressives are helpful. So, try medication but realize it isn't a sure cure.
12. Many people believe the peak rate of suicide is during holidays, such as Christmas and New Years, but fewer people kill themselves at those times. Also, fewer people decide to suicide when a national

disaster strikes, like 9/11, perhaps because people support each other when trauma strikes and attention is directed outside ourselves.

13. A commonly cited statistic is that a suicide causes six loved ones to suffer intense grief. More recent research suggests that more like 20-25 people are affected by a suicide and they often need help (*Preventing Suicide*, October, 2003). They feel guilt, shame, lack of support, and rejection by others. See the later section on treatment as well as [Compassionate Friends](http://www.tcf.org.uk/) (<http://www.tcf.org.uk/>) and [Bereaved by Suicide](http://sobs.admin.care4free.net/) (<http://sobs.admin.care4free.net/>).

14. Children of “attempters” are six times more likely to attempt suicide than children of nonattempters, especially if the mother had a mood disorder and was sexually abused, and also if the offspring is a female who has had a mood disorder, drug abuse, impulsiveness, anger, and/or sexual abuse (Brent, et al, 2002).

15. The American Foundation for Suicide Prevention (2001) estimates that 90% (others say 30-50%) of suicide victims have significant mental illness, often major depression with such symptoms as insomnia, fatigue, poor appetite, poor concentration, impulsivity, anger, high risk-taking, or addictions. About one in five depressed patients attempt suicide.

16. Anorexia Nervosa and Binge-Purge subtypes have reportedly been found by some researchers to be over 50 times more likely to attempt suicide than similar women without an eating disorder (Dr. Debra L. Franko, Northwestern University, Bouve College of Health Sciences). Also, binge drinking is associated with a higher risk of suicide, according to Dr. Michael Windle (windle@uab.edu) in *Alcoholism: Clinical and Experimental Research* (May, 2004). Perhaps this isn't surprising since some people try to use alcohol to cope with depression.

17. Three studies have found that women who have had cosmetic breast implants are three times more likely to attempt suicide than similar women who have not had an implant (Dr. Joseph K. McLaughlin, *Annals of Plastic Surgery*). The reason is unknown but some speculation focuses on the personality makeup of women who seek implants.

18. People who have once attempted suicide may remain a somewhat higher risk for the rest of their lives (Dr. Gary Jenkins [Nov. 16, 2002], *British Medical Journal*). Also, a Helsinki group of physicians came to a similar conclusion after following 100 parasuicides (self-poisoning) for 37 years (Suominen, et al, 2004). This is in line with believing that previous attempts are a sign of high risk but it seems to contradict the Sieden (1978) study cited above in “a powerful argument against suicide.” The risk declines with time.

19. Among 15-year-olds who have attempted suicide at that age, more than twice as many of them (compared to non-suicidal 15-year-

olds) had consulted their family physician during the year. Some of their concerns were about physical health, like upper respiratory illness, but many had mental health problems.

20. A WARNING: There are Web sites, perhaps several of them, that present the view that suicide should be an individual's choice to be accepted by others. Some have described their sites as "sanctuaries where people can discuss suicide in an atmosphere that is not condemnatory." Some of these sites allegedly provide directions for committing suicide and it is known that online chat groups have "egged" a person on and then watched them, via a camera, die. It is not known how many deaths are encouraged by such sites. Yet, it is something for the depressed and their families to be aware of. Certainly, a person deeply into suicidal thoughts should not be exposing themselves to morbid, dangerous, and possibly disordered thinking of an unknown and unprofessional person on the Internet.

21. Several studies have tried to determine what percentage of the general population has had suicidal thoughts. The results have ranged from 5% to 50% of us. One study by a careful Australian researcher (Goldney, 2000) estimated that 17.5% of 15 to 24-year-old women and 20.2% of men the same age had some suicidal thoughts. With so many people having suicidal thoughts, while the act is quite rare, that means that only one person actually died of suicide out of every 612 who had thought about it. That is why clinicians ask questions, use tests, and gather additional information to estimate the risks—questions like: Have you made plans? Have you thought of or prepared a way or a means? How soon will you do it? Have you told others? Thinking or talking a little about killing yourself doesn't mean you are going to do it nor that you are not going to do it. One always has to be on guard.

22. You might think that Ph. D.-level therapists would seldom get depressed or think of suicide. However, out of 800 psychologists surveyed, 84% had been in therapy, 61% with serious depression, 29% reported having had suicidal feelings, and 4% attempted it (Pope & Tabachnick, 2004). Some might think these data mean that these depressed therapists are poorly prepared to help others. I would suggest that the life experience of having had depression and overcoming it might improve their understanding, sympathy, and skills as therapists.

23. There are many myths or false ideas about suicide. Examples: (a) "People who talk about it never do it" or "People who really want to die never tell anyone." In fact, 80% have given verbal signals. (b) "Anyone who tries to kill him/herself intends to die." In fact, many attempters are undecided—still in conflict about living or dying. Often they "gamble with death," leaving it to chance or for others to save them. (c) "Once suicidal, always suicidal." In fact, most of the time that is just not true; once saved from suicide, a high percentage are grateful for a full life. (d) "The risk is over when they hit bottom and start to improve." In fact, most suicides occur during the 3 months

after starting to improve. (e) "It's the rich and beautiful (or others think the poor and unattractive) that do it." In fact, the suicide rate is basically the same for the rich and the poor and for the attractive and the unattractive. (f) "Don't ever ask a depressed person about their suicidal thoughts or plans, it gives them ideas." There is no evidence for this belief but there are strong reasons to believe that considering suicide a taboo topic has increased the number of suicides. One of the big debates in school systems is whether it is advisable to have a program about suicide after a student has died. (Probably depends on the content of the program, don't you suppose?)

Predicting suicide is very complex and very difficult

It is a very important prediction—one of the most important decisions a family, a friend, a psychologist or psychiatrist or counselor or a patient him/herself will ever make. There are so many barriers to making accurate decisions. There are no reliable tests for suicide—there are tests of depression, of pessimism, of hopelessness, of low-self-esteem, of anger or conflict, but many people have high scores on those tests without being a suicide risk. There are no interview questions to ask that can be safely relied upon and no "I-Won't-Kill-Myself-Before-I-See-You-Again" contracts to sign that insure staying alive. For one thing, there is no reason to believe a suicidal person will tell their interviewer the truth. About 25% of suicidal patients never admit being suicidal (*Psychiatric Times*, September, 2002). Indeed, the seriously suicidal person may view the interviewer as an enemy who is likely to oppose his or her plans.

One of the ironies of suicide is that it is both so important and so secret. These lethal thoughts are perhaps most likely to be changed by considering a different point of view; yet, suicide is one of the most private secrets many people will ever have. Plans for suicide are often kept very secret, yet the usual immediate and long-term consequences in other peoples' lives are enormous. People may kill themselves feeling unloved, totally alone, and deeply ashamed, while, in the eyes of others, they are loved, genuinely cared for, and would be completely forgiven if their shortcomings were disclosed in detail. Dr. Shawn Shea (1999), the Director of the Training Institute for Suicide Assessment, has skillfully discussed these dilemmas in his interesting and excellently written book, *The Practical Art of Suicide Assessment*. He also mentions philosopher Schopenhauer's interesting observation of another paradox about suicide, namely, a conscious mind that seeks death may often hope to answer questions about the afterlife and God...i.e. after consciousness is destroyed. Giving up life to test religion hardly seems wise. Although his book is mostly for professionals, I'll mention Shea again a little later.

Remember that surely 20% (maybe a lot more) of people have thought of death as a solution, but only 1 out of 600 who have had suicidal thoughts actually kills him/herself. That low frequency also makes predictions very hard to calculate. Science is learning more and more about predicting, preventing, treating and understanding the

nature of suicide. We need to learn a lot more. Jacobs (1999) has edited a comprehensive book covering suicide assessment and intervention. It is mostly by and for physicians or psychotherapists, costs \$75, and needs to be updated, but its 48 experts cover in depth a wide variety of special topics in this complex area. For a good discussion of assessing and intervening with adolescents see Kirk (1993).

It is true that a quite a bit is known about the kinds of people who kill themselves—we know many of their characteristics, particularly what groups they belonged to (such as age group, suffered serious losses, fought with spouses, had addictions, etc.) but these group characteristics are not closely linked to suicide in every individual case. Most people in these groups do not die by suicide. It is important to recognize that accurate predictions of suicide are almost impossible if you are trying to judge or predict if one specific person will live or die in the next year. On the other hand, it is pretty easy to determine how many in a town or an organization or a state have killed themselves in the last year and then predict how many within that group will kill themselves in the future over the same period of time. Why is it so hard to make individual predictions? Because suicide is such a rare event that the most statistically accurate prediction is “he will probably be alive this time next year.”

For a specific group of 100,000 people, the yearly suicide death rate is likely to be somewhere around 10 because that is the national average in the US. Note: when predicting deaths in a group such as this, we don't have to say exactly which 10 of the 100,000 will die. But when considering just one person, Joe Smith, the best bet almost always is that he will be alive like 99,990 other people in the group and not be one of the 10 that die of suicide. The best tests and the best experts can not predict well enough to overcome those odds. However, clinical judgment, plus a good history of the individual, the right questions, and several psychological tests may detect significant “warning signs” (such as thinking of suicide, drinking problems and previous attempts) which can certainly increase the accuracy of estimating the risk of suicide for a specific person. Thus, an experienced clinician might judge that “the risk of suicide for Joe Smith is very high,” meaning a constant suicide watch is advisable. Perhaps the clinician thinks there is one chance out of three of Joe Smith dying of suicide within a year. That is a very dangerous risk requiring many precautions with Joe but Joe's death can't be predicted with any certainty. Soon we will discuss more of the indicators or warning signs of suicide which are, at best, crude predictors that we can use for now.

However, for a moment, it is also appropriate to view the prediction situation from the standpoint of a professional helper who is expected (legally required?) to do a systematic suicide risk assessment. This overall assessment has to be thorough and accurate enough to take reasonable steps to prevent suicide. The therapist has to act promptly enough to care for the patient until the treatment and medication start having a beneficial effect. This initial stage of

treatment is fraught with possible crises, such as the patient having panic attacks, intense guilt and shame, serious insomnia, having to disclose suicidal depression to family, or going through withdrawal from addictions, any one of which might push the patient into suicide. This situation can be demanding, frustrating, and very uncomfortable for the professional, too. The therapist may have a deep personal involvement with the patient. Moreover, his or her professional reputation and career as well as financial well-being are at risk. Suicides account for the largest number of malpractice lawsuits filed against psychiatrists (Robert Simon, *Psychiatric Times*, September, 2002).

Possible warning signs

Wide assortments of lists of warning signs have been published. I'll give you three or four samples. The same warning signs appear on many of the lists, but they all have unique ways of predicting. Professionals disagree about how many suicide victims have suffered from depression, ranging from about 50% to over 80%. But it is accurate to say signs of depression are serious warnings. Also, one in four suicide attempters have a family history of suicide. Alcohol and drug use are warning signs because they are related to impulsiveness and poor judgment. Sudden mood changes are another sign. Also, previous attempts (25%-40% have tried before), verbal hints ("You won't have to worry about me much longer"), suicidal talk and especially specific plans, preparing behaviors (giving away prized possessions, getting affairs in order), moodiness and social withdrawal, mental problems, preoccupation with death, carrying weapons, taking risks, and doing poorly in school or at work are common. In many cases there has been a loss--health, economic, self-esteem, love, pride--or involvement in an addiction, crime, homosexuality, or divorce. 75% of teenagers attempting suicide report family problems; many have a psychological illness as well. For some reason, panic attacks and migraine headaches are associated with a greater risk of suicide. Almost any loss, conflict, or crisis increases the risk of suicide (Neiger & Hopkins, 1988; Lester, 1992). Don't be misled by the common misconceptions or myths about suicide mentioned above.

We've discussed that scientifically predicting suicide is hard. There are so many variables to consider. But Lewinsohn, Rohde, & Seeley (1994) found that 73% of a sample of teenagers who had attempted suicide had 3 or more of these 6 warning signs: (1) previous suicide attempt, (2) suicide attempt by a friend, (3) suicidal thoughts, (4) depression, (5) low self-esteem, and (6) being born to a teenage mother. So, objective measurement of warning signs is promising. Remember, however, that warning signs that identify 73% of this sample of attempters may not be very accurate in predicting attempters within much larger groups where false positives may be frequent. More about empirically assessing individual suicide risk-takers will soon be made available in *Life Attitudes Schedule* by the above authors. It is to be published by MHS (<http://www.mhs.com/>).

The National Alliance for the Mentally Ill provides a list of signs of depression and suicide risks something like this:

1. Changes in mood or personality, e.g., sad, irritable, apathetic, withdrawn.
2. Behavioral changes, e.g., disinterest in school, can't concentrate, changed habits.
3. Different sleep habits e.g., can't sleep or over-sleeps, awakes early.
4. Different eating habits e.g., lack of appetite or over-eating.
5. Less social interests, e.g., withdrawal from friends or usual activities.
6. More worries, e.g., health concerns, the future.
7. New fears of going crazy, hurting someone, losing self-control.
8. Dwelling on self-criticism, guilt or shame, self-disdain, or disgust with others.
9. Increased hopelessness, e.g., things will never change, I can't stand it.
10. Frequent and highly emotional dreams or nightmares.

Experts, in general, say the 5 or 6 better predictors of actual suicide include (a) a history of non-lethal self-injuries (but 90% never kill themselves), (b) being a male (6 males to 1 female die as young adults and 20 men to 1 woman among the elderly), (c) being older, (d) being white, (e) having some psychiatric diagnosis (but less than a third of those who commit suicide have had contact with psychiatric services), and (f) having a recent history of a major loss or disappointment. Maybe as many as 85% of the people who died by suicide would have been considered depressed if they had seen a professional, but a lot of depressed people are not suicidal. The lack of treatment is still a major societal problem. So much more research is needed, e.g., there are even disagreements about crucial questions, such as whether taking anti-depressants lowers the rate of suicide by adolescents (some data suggests it increases the risk—see findings mentioned later).

A caution: When reading about the many and varied predictors or "warning signs" of suicide, please do *not* assume that having a couple of warning signs means that suicide is imminent. It may happen, of course. But I hope it is clear that many of the signs can be common when one is emotionally upset in any way and not suicidal.

Another caution: Do not allow the frequency of a sign's occurrence or long lists of warning signs lead you to the belief that suicide is a common or acceptable solution to serious distress. Suicide, in my opinion, is a totally unacceptable, not thought through, and misguided solution to any troubling situation. Remember, a high percentage of people prevented from killing themselves have gone on to live a happy, productive life and were deeply grateful for having a full life. Things change.

One more final comment about warning signs. Shea (1999) makes this point very well. Because warning signs are easily identifiable and countable, even clinicians may be prone to base their predictions largely on warning signs. Shea reminds us that the decision to kill ourselves comes from the mind's perception of the psychological pain we are suffering, not from a count of warning signs. Thus, the best predictions (and the best help) are based on getting to know intimately the reasoning and the feelings leading to the decision to die. This decision often lingers on for days, weeks, months or years of detailed thought about the various pros and cons and about the consequences of using different methods (all this thinking pushed and influenced by emotions). If the therapist is caring, lucky, and understanding, the doctor may be invited by the patient to see the complex and intimate journey the mind has taken and why. With that insight, then, perhaps, better predictions can be made and, more importantly, maybe alternative solutions can be tentatively discussed. In his book, Shea provides a strategy for getting this process moving and giving good therapy, called the Chronological Assessment of Suicide Events (the CASE approach). These hours are precious for both the helper and the helpee.

Too often there isn't enough time for the "CASE" approach, even if the patient has good health insurance. Much of the time, professionals assessing the lethality of suicidal intentions have to rely on warning signs and a brief mental health history.

The importance of Shea's notion of understanding the person's thinking and intentions is underscored by a very thorough 12-year follow up of 224 suicide attempters done by four Finnish hospitals (Suominen, Isometsa, Ostamo, and Lonnqvist, 2004). Trained interviewers asked the attempters 424 questions about their everyday life, health, alcohol and drug use, suicide attempts, health care, psychiatric treatment, and life events. In addition, a large test battery was administered, including Beck's Suicide Intention Scale, Beck's Hopelessness Scale, State-Trait Anger Scale, Self-Esteem Scale, Motives for Parasuicide Scale, and Beck's Depression Scale. The Finnish investigators found that during those 12 years of follow up 22% of that group had died but only 8% had died from suicide. This 8% were found to have scored very high on the Suicide Intention Scale when they first came to the hospital. This high intention (a strong wish to end one's life) was the best predictor of eventual suicide perhaps years later, better than previous attempts, hopelessness, gender, age, psychiatric disorders, health, or other

more common predictors. Therefore, previous attempters who at the time had high intentions of dying should be considered serious risks for many years. It is important to understand in depth the reasons why a person wants to die and why it is so important to them.

Another innovative approach to predicting suicide has recently been reported by Silverman and Simon (2001). One of the problems in studying suicide is that the main source of information is dead and unable to provide a history of the event. The Houston Case-Control Study of Nearly Lethal Suicide Attempts is a partial solution to this problem. By selecting 153 cases who used highly lethal methods (e.g. a gun shot to the head that ricocheted off the skull) but survived or who were saved only by extraordinary medical attention, the investigators hoped to get better insight into suicide. These highly lethal attempters were both compared to 47 less lethal attempters and sometimes with a matched non-suicidal control group. This study did find different relationships. For example, although many experts and earlier studies have associated suicide with serious psychiatric problems, this study found that *less lethal* suicide attempters had *more serious* psychological problems. That is, the somewhat less serious attempters had a history of making more previous suicide attempts, had more serious psychiatric symptoms, reported more hopelessness, and were more likely to have phobias or panic disorders. There is, thus far, no explanation of these different results. There was no evidence, in term of telling someone their plans, calling someone for help, picking a place where you might be discovered, and expecting to die less, that the lethal attempts were a "cry for help." In addition, lethal attempters were more likely than less lethal attempters to have frequently changed residence, to be alcoholic, and to have been drinking within 3 hours of the suicide attempt.

With much more careful, innovative research, like what we have just reviewed, we can acquire the knowledge needed to reduce the 4,500 yearly deaths caused by completed suicides (12% of all deaths among 10-24-year-olds) and the 125,000 yearly ER visits caused by non-fatal suicides in the same age group.

Prevention and treatment

Sometimes suicide prevention should have started at a very young age, because self-concept, mood level, and attitudes (e.g. optimism and trust) usually have a long history closely related to family and early experiences. It may be possible to deal with some of those long-term difficulties later. The best prevention is quick attention to emotional problems when they occur, and to maintaining good mental health.

In the last section about prediction, many of the more common signs of risk or warning signs for suicide were mentioned. Each of those warning signs that seem to be especially troubling spots for you could be contributing to a self-destructive tendency and could be worked on in counseling to reduce the risk of self-harm. In addition to

long-term personal-emotional problems, a therapist would ask about especially distressing events in your life right now (and you can ask yourself how important these factors might be), e.g., are you having problems at work or school? Troubles with friends, boy/girlfriend, spouse or parents? Feeling no one cares? Have you failed or let yourself down? Are you really angry about something? Any major problems, such as being in trouble with the law, an unwanted pregnancy, major losses of money or pride? Using drugs or alcohol? Thinking about suicide, talking to friends about it, writing or drawing about death? If problems have piled up, it is vitally important to get professional help and to get busy using self-help methods.

Even if you have done all the right things—informed your family about your serious depression, gotten a therapist, checked on taking anti-depressive meds, started to deal with emotional problems—whenever you sense you are getting close to a suicide attempt, it is a critical time period and there are important things to think about and do. For example, first make sure you have an agreement with your therapist about calling him/her at any time for help. Find out exactly how to get him/her at all hours at the office or at home. If your doctor has arranged a part-time backup, know exactly how to get that person, too. Carry those numbers with you all the time. Call your therapist as soon as you need to. Do not ignore suicidal thoughts or urges. Don't put off calling for help. Also, know the best procedures for getting to ER and for being admitted to the hospital. In addition, find out how to contact your Community Mental Health Center and/or a local Suicide Prevention Service; they sometimes have an experienced mobile crisis team that can immediately respond (one advantage for calling them is that ordinarily they would not involve the police). If you can't get all this information pulled together yourself, ask a relative or close friend to get it for you. Be sure you talk to your therapist about what you should do if you feel close to suicide...and find out what the doctor will do if you need him/her in an emergency. Know how to use 911. Neglecting getting help at this stage is very serious.

It is also important to stay in frequent communication with family members. Keep them posted about how you are doing and where you are located. If possible, spend time with friends or at work or in some outside-the-home activity. You need to keep your mind occupied and off of repetitively thinking about how sad, bad, or mad you are. Get rid of all guns, sharp objects, lethal amounts of drugs, or anything dangerous. If possible, do not stay at home alone for extended periods of time. To get the location of a *local face-to-face* support group in the USA, dial 1-800-SUICIDE, call your Mental Health Center, or go to [Suicide Hot Lines](http://www.suicidehotlines.com/) (<http://www.suicidehotlines.com/>) and click on your state. If you find or already have an *online* support group, they can be helpful, but in a suicide situation a friend on a list is severely limited by being 2000 miles away and not knowing how to reach you or your community or your treatment team. Your therapist can help you find a nearby face to face support group. It is important to have people to talk to. Some believe that one reason African-Americans have a low suicide rate, especially the women, is because of

the social support and religious faith 90% of them get in their communities. Black churches are especially helpful to members through times of trouble.

Mental Health Centers and suicide prevention

Since the 1960's, when the Community Mental Health Centers were established, one of their responsibilities has been to establish a suicide prevention program within each county. Many did but funds have dried up. In 1998-1999, the Surgeon General, Dr. Satcher, published a renewed "[Call to Action to Prevent Suicide](#)" (<http://www.surgeongeneral.gov/library/calltoaction/>). It set sweeping goals, such as community programs that *build life skills and values* that reduce the risk of suicide, making suicide risk assessment part of regular health care (as provided by your family physician), increasing insurance coverage for mental health problems, increasing public awareness that suicide is often related to mental illness, increasing support to survivors, training doctors, teachers and ministers how to help suicidal persons, and getting the public more aware of and sympathetic with people suffering suicidal thoughts. Anyone starting to think that suicide might be a solution for them deserves our concern and empathy, not our disdain and neglect.

Recently, [The National Strategy for Suicide Prevention \(NSSP\)](#) (<http://www.mentalhealth.samhsa.gov/suicideprevention/>) has revived, again, a big program (unfortunately more plans than money) to encourage each state to improve or develop and operate an effective prevention program. This Web site tells about current events in prevention, makes available many of the major programs and articles in the suicide prevention area, and gives a link to specific suicide services and resources in your county (if your state has done its work by now). I mention this mostly so you (reader or counselor) will know that prevention services and on-going treatment for any problem associated with depression or suicide should be available at an income-adjusted price near you.

Suicide prevention in young people

If you are in school, ask your Counselor or School Psychologist where to get help. There are several Suicide Prevention Programs designed for schools; most attempt to lower depression and the risk of suicide while a few other programs try to help friends and relatives cope with grief and guilt following suicide. There are instances where suicides occur together, called contagion, after a schoolmate's suicide. Two of the better Web sites for reviewing suicide prevention programs are (1) [UCLA Mental Health in Schools Training Center](#) (<http://smhp.psych.ucla.edu/>), School Interventions to Prevent Suicide, January, 2003 and (2) [American Academy of Pediatrics](#) (<http://www.aap.org/healthtopics/depression.cfm>), including "Some things you should know about preventing teen suicide" as well as other articles.

The many prevention programs, mostly for teens and schools, mentioned in these major papers need to be carefully studied, replicated everywhere, and improved. About 4% of high school students have made a suicide attempt in just the last year and 8% have made at least one attempt in their short lifetimes (American Academy of Pediatrics, 1996). A new book by Spirito and Overholster (2002) should be mentioned because it deals in depth with this topic, namely, assessing and treating teenage suicide attempters. Suicide is a burgeoning psychological crisis that needs our utmost attention. Some good work has been done but much more is needed. I'll describe a few specific programs already carried out that could provide the basis for much more effective programs to decrease suicide.

The United States Air Force had an unusually high rate of suicide in the middle 1990's and developed a program to reduce the number of deaths. They arranged for both military and civilian agencies to concentrate on supporting AF personnel having mental health or psychosocial problems by urging them to see a counselor. In effect, they hoped to remove the stigma associated with "seeing a shrink." The result after the program was put into practice in 1997 was a 33% reduction in suicides. The evaluators also found that homicide, spouse abuse, and accidental death also went down (Knox, K. L. et al., 2003). Thus, relatively gentle encouragement to seek help when one is down seems to yield benefits.

An extraordinary group of Oregon psychologists have produced impressive programmatic research about assessing and treating depression, suicide, and many other problems. Their test for assessing the risk of suicide was cited in the last section (Lewinsohn, Langhinrichsen-Rohling, Rohde, & Langford, 1995). Recently, they (Lewinsohn, Rohde, Seeley, & Hops, The coping with depression course: A psychosocial treatment of adolescent depression) have made their extensive [Psychosocial educational material](http://www.kpchr.org/public/acwd/acwd.html) (<http://www.kpchr.org/public/acwd/acwd.html>), dealing with adolescent depression, freely available online to therapists, counselors, and teachers. They make it clear that their teaching manuals and aids are for trained group leaders, not for self-helpers (Lewinsohn, Clarke, Rohde, Hops, & Seeley, 1996). But the educational approach they advocate and the how-to-cope topics they cover are rather similar to skills training methods presented in self-help books, including this book. Young people need the guidance schools can give. I strongly recommend that counselors working with depressed and suicidal students make use of the work from Oregon.

There are especially designed treatment programs for suicidal adolescents. Examples: Piacentini, Rotheram-Borus, & Cantwell (1995) propose a Cognitive-Behavioral, highly structured, 6-session, family treatment program directed towards creating more positive family relationships. Brent, et al (2003) compared the effectiveness of three different Psychosocial approaches to helping depressed and suicidal teens. And, finally, Asarnow, Jaycox, and Tompson (2001) reviewed the research covering different methods of intervening with young

people with depression. They found the Psychosocial/Cognitive-Behavioral approaches work quite well and, based on those results, they suggest a working model for therapy. The focus of these studies is on the effectiveness of short-term therapy with depressed teenagers.

Special mention needs to be made of Coombs (1990) who with the help of professional organizations (counselors, school psychologists, nurses, social workers, and principals) developed a training "SOS Manual" for (a) directly teaching students the warning signs of suicide (in themselves and others) and then encouraging two prompt responses to a person with those signs: (b) showing they care and want to help and (c) telling a responsible adult. The recommended emergency-like procedure is called ACT, standing for ACKNOWLEDGE the signs, show you CARE, and TELL an authority. Every young person should know ACT, just like CPR. This is not a therapy approach but an educational program that helps students recognize serious depression in others (and in them) and then gets help.

Aseltine & DeMartino (2004) did a large randomized control study of the ACT method for stopping suicide and found that this program reduced suicide attempts by 40%! That is an impressive finding, suggesting that suicide attempts and suicides could be substantially reduced by 1 or 2 hours in the classroom costing about 40 cents per student. Since 2000, this program has been implemented in over 1300 schools, so it should soon be possible to determine if ACT training reduces the number of suicides or just the number of attempts and if the number of attempts are actually reduced or just the number reported on a self-report three months after the training.

On the other hand, the numerous evaluations of two hour "general education programs" about suicide have yielded mixed results. See [UCLA Sch Psy](http://smhp.psych.ucla.edu/) (<http://smhp.psych.ucla.edu/>). The programs usually consist of suicide statistics, warning signs, and mental health resources, much as I am doing in this book. Often students say they already know this stuff (of course!) but they learn some facts. Yet, they don't seem to change their attitudes about suicide nor learn more techniques for coping with depression nor become more inclined to seek psychological help. In fact, students *who have attempted suicide* do not find the program helpful, are even more reluctant after the program to talk about their suicidal thoughts, have less confidence in mental health professionals, and still see suicide as a possible solution for them. Some educational programs sensationalize suicide and others normalize it; both not good. There are questions: Do school programs make students too responsible for stopping suicide in fellow students? Do students, who have already attempted suicide, become more likely to try again after a program? Some researchers and administrators think so. Obviously, the impact of a program depends on how the information and experience are processed within each student's mind. That can't be predicted perfectly. However, we need more knowledge so the program content can be tailored to each kind of student.

The frequency of suicide among teenagers has doubled in the last 30 years but has held steady or declined slightly in the last 10 years between 1994 and 2001. However, we should be aiming to do much better at prevention in the future. A national suicide prevention program, TeenScreen, will survey 13,000 teenagers in 2004, but there are many more to screen. If the family physicians who are heavily prescribing anti-depressants to teens would also push psychotherapy (regretfully less than a third of teens with major depression are in therapy), more suicide could be prevented. If more public education openly connects the treatment of mental-emotional problems with the prevention of suicide and, thus, enlightens the teenagers' parents, the result will be much better treatment. And, if research of detection, treatment, and prevention methods were sharply increased, we would save many of our best young minds.

Hospital treatment

Katherine Anne Comtois (2002) reviewed the 1970 to 2001 studies of the treatment of parasuicides (defined as any non-fatal intentional self-injury, including more or less lethal suicide attempts and self-mutilation). Such a review is important to determine how well we are handling suicide attempts and to figure out how we can respond to them better in the future. It is estimated that 5% to 10% of the US population will reach the point of attempting suicide sometime in their life—this percent may go up as we get better records. Without any doubt, a history of parasuicide (prior attempts) is a very important factor in predicting suicide. Amazingly, not much is known about the “usual treatment” in terms of what treatment or care is usually given (a) before parasuicides, (b) while the patient is in ER, (c) while in the hospital or (d) when doctor's orders are given at discharge. Comtois reports that there are few studies with adults. Some studies have shown that a much higher percentage of persons destined to parasuicide have seen their family physician in the previous year than is true of the general population. So, persons at high-risk for self-injury often have access to the medical services...and they are not reluctant to see a doctor. Apparently, their depression and suicidal thoughts are *not* communicated as they should be.

Certainly, quick and secure hospitalization in an inpatient psychiatric unit is a critical step in saving lives but little is known about how effective it is in reducing depression or subsequent attempts or in getting the patient to seek effective outpatient treatment. We do know it is terribly expensive. We don't yet know how effective alternative treatments to typical short-stay hospitalization might be. But we have some hints.

Only a few studies of alternative hospital or post-hospital treatments have been done following the 500,000 suicide attempts per year in the US. In general, although some individual physicians do a good job, most studies have found that the typical hospital and post-hospital treatment programs did *not* lower the subsequent suicide rate. Comtois (2002) looked closely at this topic and found five limited

studies of special post-hospital treatments that *have demonstrated some success*: (1) Dialectical behavior therapy (extensive therapy and group *for one year*), (2) Cognitive-Behavioral problem-solving (5 sessions in home), (3) home visits reinforcing attendance to outpatient therapy, (4) medicine given by shots for six months, and (5) Psychodynamic interpersonal therapy (4 sessions by a nurse in home). Besides these treatment programs, Dr. Comtois concluded that several changes in inpatient care might reduce the suicide and parasuicide rates, such as: (a) keeping better records about the patient's specific means of self-injury, the dangerousness, the use of drugs or alcohol, the presence of schizophrenia or bipolar disorders, and other high-risk factors, (b) routinely evaluating the quality of care and outcome of hospitalization, (c) improving the training of physicians and staff dealing with parasuicides, (d) being sure treatment guidelines are followed, (e) facilitating post-hospital care including meds, referral to outpatient treatment and to support groups, and (f) providing after-care, paid by Medicare, for distressed relatives (much as Hospice does).

If you aren't getting optimal service from your hospital, then perhaps someone should complain to the head psychiatrist. Providing marginal service at these crucial times is dangerous to the patients and to the doctors. Suicide and parasuicide cases are among the most often associated with malpractice suits. If you already have a therapist before being hospitalized, then you should be OK because you can quickly go back into individual therapy. If you are trying to make an appointment with a new doctor who tells you there are no openings for 2 or 3 months, please tell him/her that you need to be seen right away and that you were just in the hospital and still feel suicidal. They need to know your condition in order to protect you...and you need to tell them your mental condition. If that doesn't work, see another therapist. It is not unusual for suicide to occur during or shortly after hospitalization. This is a dangerous time. Relatives and friends may also be very distraught. They may need help too.

Cautions concerning the use of antidepressants

Although all depressed or suicidal people should get medical advice and carefully consider using medication, it is unfortunate that many people may believe (wish?) that all they need to do to control their depression is see their family doctor and get some pills. There is a lot of faulty thinking involved here: first, GPs have little training in psychiatric disorders, such as depression or bipolar. Psychiatric or Clinical Psychology specialists are needed. Secondly, many psychopharmacology manufacturers say the physician should refer the patient to psychotherapy whenever an antidepressive prescription is written. That is seldom done. Third, it is generally believed that anti-depressive meds take 6 weeks or so to start working. What protects you during those 6 weeks? Fourth, it is well recognized that even the best anti-depressive medication does *not* work with all patients, maybe only with about two-thirds of them. What if you are within the 33%? Fifth, what if your depression is not caused by "chemical imbalance"

but rather by a crushing loss or failure, intense self-criticism, pessimistic thinking, unreasonable guilt, etc.? Can you count on a tiny pill to straighten out all these questionable ideas? Maybe or maybe not (certainly no one today can tell you with confidence which causes of depression are modified by drugs and which are not).

Public Citizen, a consumer protection group, petitioned FDA early in 2003 to ban Serzone because it is thought to cause liver toxicity. Also, several parents who have lost children have complained to the FDA about antidepressants (SSRIs). Some of these drugs have been removed from European and Canadian markets. Within the last year more governmental agencies (including the FDA) have warned physicians to be on guard because some SSRIs may increase crying, suicidal thoughts, and suicide attempts in young people under 18 years of age. Public Citizen is now (March, 2004) suing FDA because it has not acted. An [investigating medical organization, ACNP](http://www.acnp.org/default.aspx?Page=Home), (<http://www.acnp.org/default.aspx?Page=Home>) was appointed to investigate this situation; their report is due by summer, 2004. The ACNP believes, for now, that SSRIs do, on average, more good than harm in children and adolescents. The data about the effects of anti-depressive drugs in youth remains unclear: one autopsy study (Gray, Moskos & Keller, 2003) of 49 adolescents who died of suicide found that only 24% had been prescribed antidepressants and all of these 12 subjects had no SSRIs in their system, i.e., they hadn't taken their medicine (wonder why?). The ACNP group at first concluded that since no young person in this study who died had actually been taking antidepressants, it meant that medication might have helped prevent suicide had it been taken. Yet, this study raises more questions than it answers. There is certainly no strong evidence for using these meds with young people. In fact, several studies of adults have also found antidepressant meds to be no more or just barely better than a good placebo. The ACNP group has already concluded that an older anti-depressant (tricyclics) is inappropriate for adolescents. Conclusion: While millions of adults believe antidepressants have improved if not saved their lives, there are reasons to be cautious about expecting too much from the drugs, especially when giving adult meds to young children and adolescents.

Intensive individual psychotherapy

Most suicidal people suffer from depression in some form but all depressed people are not suicidal. Depression and low self-esteem have been studied for many years. There are several types of depression, some severe and some a lingering cloud of mild gloom. Except for the most devastating severe depression, it can usually be successfully treated with medication and psychotherapy. Therefore, everyone who has the slightest inclination towards suicide should immediately be encouraged by relatives and friends to get into therapy with an experienced, fully trained and licensed psychotherapist and to be evaluated by a psychiatrist for antidepressant drugs. I would recommend that you request your health insurance (probably via a referral from your primary care physician) to provide you with a

psychiatrist (not your regular doctor, even though he/she prescribes antidepressants). Then get psychotherapy from the psychiatrist who prescribes your psychotropic drugs (if he/she does talking therapy) or from a doctoral level clinical psychologist, or from a social worker covered by insurance. Unlicensed and lesser trained counselors are not likely to have the experience, the authority or the status needed to deal with a crisis involving a serious suicide attempt.

In most cases, I also would not recommend accepting limited therapy. Suicide warrants highly qualified professionals and intensive, long-term psychotherapy. Beware of a doctor who recommends that you have a therapy session once a month or for just 15-20 minutes a week. If the doctor who prescribes your drugs makes that suggestion, tell him/her that you would like to have both meds *and* psychotherapy. If you are a college student, your Health Service and your Counseling Center should provide you with both of the services you need. If you are not covered by health insurance and don't have a rich, sympathetic relative, then I'd go to your local Mental Health Center. They should provide psychotherapy at a rate you can afford and arrange for you to get drugs from a psychiatrist consulting with the agency.

I will not discuss at this point therapy for depression or other psychological conditions related to suicidal thoughts because a full discussion is already in other parts of this chapter or other chapters. It is well documented that psychotherapy, especially Cognitive-Behavioral Therapy, is in general at least as effective as antidepressant medicine, if not more effective. But psychotherapy may cost more and take longer.

As I repeatedly said elsewhere in this book, it is wise to supplement psychotherapy with self-help readings and efforts. Of course, the psychotherapist you are seeing should be fully informed and involved in planning and monitoring all self-control or self-improvement efforts you undertake. There are so many useful self-help methods: improving self-esteem, increasing optimism, living according to your values, overcoming unwanted habits, improving sleep, coping with stress, worries and trauma, improving health, increasing happiness, reducing shame and guilt, mellowing anger, handling relationship problems, finding and keeping love, increasing tolerance, reducing irrational ideas, stopping bad memories, increasing insight and self-understanding, etc, etc. They are described in this book. Look them up.

Self-Help is only a supplement to therapy when suicide is a possibility

As I hope I have made very clear, preventing your own suicide is not a self-help project. If "ending it all" is on your mind, your first priority is taking preventative action (see the first few paragraphs in this section), then get professional help right away. If you are an adult, you should probably also get anti-depressive medication as soon

as possible and give it a try for several weeks (don't expect much for 4 to 6 weeks). Several research studies show that anti-depressive meds may help prevent adult suicide (more doubtful with teenagers). Don't put off taking drugs because you want to do it on your own or you just don't like the idea of drugs or because you don't want to tell the doctor you are quite depressed. As I mentioned, be frank with your doctor.

The usual self-help approaches to suicide involve dwelling on and making a list of all the reasons for living--the people who care about you and the pain suicide will cause them (many people you know will probably think they are at fault if you kill yourself). List the things you could do with your life, talents you have, things you could enjoy and would miss, etc. As described in chapter 2, make a list of self-improvements you would like to make. Get started on a couple. Do some self-analysis: Realize you are of two minds; part of you doesn't want to die--strengthen that part. If you are self-critical or self-defeating, realize that you have an optimistic, capable side that can lead to positive outcomes in life. If you are self-absorbed, thinking mostly of yourself, broaden your world--seek friends and learn the skills and look for ways to help others. Seek the reasons for your sadness—use this entire book to plan self-help projects. Most important, get active--DO SOMETHING! Be social! Get started changing your situation and your outlook (find your purpose in chapter 3). Defeat the lethargy. Maybe drastic changes are needed. One therapist observed, "It's not keeping people from killing themselves, it's helping them find reasons to live." That's self-help.

Two books are of special value because they have been written for people in the midst of suicide. Both serve well as a treatment manual for the therapists of such patients but the books are also self-help oriented, which in my opinion is the optimal approach. Ellis and Newman (1996) almost a decade ago wrote a highly rated self-help book, *Choosing to Live: How to Defeat Suicide through Cognitive Therapy*. It focuses on both the hopeless, depressed person and on the high conflict, emotional, impulsive person, helping each understand his/her feelings and thinking. This book also provides understanding and comfort to family and relatives (Norcross, 2003). More recently Spirito and Overholser (2002) addressed how to assess the future risks and the profiles of adolescents who have attempted suicide. They also present case reviews and detailed techniques, including self-help, for helping previously suicidal patients.

Helping a friend

If you are concerned about a friend's suicidal thoughts, remember: (1) Be with them as long as they need to talk. Show you care and are trying to understand their situation. (2) When appropriate, ask about suicidal thoughts. If they talk or even hint about suicide, talk openly and matter-of-factly about suicide. (3) Don't immediately urge them to think differently about the situation, just let them know you want to know "how they are feeling and looking at things." Don't panic or avoid the subject, take them very seriously. Accept their feelings. Be non-

judgmental. Don't debate whether suicide is right or wrong or whether their feelings are right or wrong or good or bad. Don't lecture on the value of life or on how terrible suicide would be. Just patiently listen. (4) After understanding their situation (and letting them discharge their emotions), then gradually and patiently do your very best to convince them to accept getting into treatment with a professional person. (5) If they resist, tell them how important it is that they make an appointment. If necessary, agree to make the appointment for them and offer to go with them if they would like that. (6) If it just isn't possible to get them to see a doctor, tell their relatives and/or other friends about the situation and work with others to get the help that is needed. You may make a friend mad by disclosing their dire situation, but as one suicide expert says, "It is better to have a mad friend than a dead one". (7) Continue to be available and concerned. Suggest that they do things with you and other friends. Don't leave them alone for long periods of time.

If a friend or relative starts to rely on you when he/she is suicidal, you must be sympathetic to the pain he/she is suffering but guard against becoming, in effect, his/her main "therapist." Insist that he/she see a therapist. Don't get caught in the situation of being repeatedly called when the friend/relative is depressed at 2:00 A.M. or drinking and crying at a bar at closing time. Your friend/relative needs professional help; if you rush to rescue your friend every time, you may be an "enabler" and actually interfering with him/her getting a therapist. It is hard to insist that they get therapy, especially when they say "you are the only one who understands me...or can help me," but you aren't the right person to handle this situation.

Suicide of a loved one is hard to accept; it is deeply disturbing and shocking, it may make you ashamed, guilty, mad, relieved, or all mixed up. This is especially true if you have allowed them to depend entirely on you for help. Getting help for them is the right thing to do. See Rosenfeld & Prupas (1984) and Wroblewski (1995) if you, as a survivor, are troubled by a suicide and need to understand.

Be warned that about 10% of people who have tried and failed will try suicide again within 3 months. That percentage increases, if they don't get help. That's why you must insist your friend or relative get professional help; force them to see a professional, if you have to. If your friend does kill him/herself, you will probably need to read about it and talk about it with a friend, or a support group, or a counselor (Hewett, 1980).

Finding helpful and useful information

To talk with a suicide prevention counselor by phone:

National Hopeline Network: 1-800-SUICIDE (1-800-784-2433) or 1-800-999-9999 or 1-800-827-7571 or 1-888-248-2587 (you may get a counselor directly or a person who will quickly transfer you to a counselor in a prevention center near where you live). Information

about this phone crisis service and the nation-wide system of 250 Community Crisis Centers is also available at the [National Hopeline Network](http://hopeline.com/4/map.asp) (<http://hopeline.com/4/map.asp>).

There are also national and international phone or (if international) email crisis services. Go to [SuicideHotlines.com](http://www.suicidehotlines.com/) (<http://www.suicidehotlines.com/>) and click on your state. A similar site is [Suicide and Crisis Helplines Around the World](http://www.sprc.org/featured_resources/links/showlinks.asp?catID=1) (http://www.sprc.org/featured_resources/links/showlinks.asp?catID=1). [Befrienders](http://www.befrienders.org/) (<http://www.befrienders.org/>) have 31,000 volunteers and serve in several languages around the world over the phone or in email.

Look up your local Mental Health or Suicide Prevention Center in the phone book (call 911 if you can't find the number). Most centers have a suicide prevention service.

To find an online support group:

There are not many, if any, support groups specifically for people contemplating suicide for reasons you can understand. Your local Mental Health Center may be the best source of information about local face to face support groups for persons suffering depression. Also, several of the big Mental Health Web Sites have groups for depression (but not explicitly for suicidal people).

There are several online support groups for relatives and friends grieving and going through a death by suicide. A large number of groups are listed by [SOLO—Survivors of Loved One's Suicide](http://www.thrivenet.com/stories/stryarch.shtml) (<http://www.thrivenet.com/stories/stryarch.shtml>), including groups for grieving parents, spouses, teens, grandparents, and many others. The American Suicide Foundation (1-800-ASF-4042) will refer you to support groups. [Friends for Survival](http://www.friendsforsurvival.org/) (<http://www.friendsforsurvival.org/>) (1-800-646-7322) and Ray of Hope (eroff@juno.com) will also help you find a support group.

Information about suicide on the Internet

There are many sites. I will give you a few of the better ones (and then add comments about some of doubtful value). [Yahoo! Site Listings](http://dir.yahoo.com/society_and_culture/death_and_dying/suicide/) (http://dir.yahoo.com/society_and_culture/death_and_dying/suicide/) links you to 50+ suicide sites. No evaluation of the sites is given.

Information for persons actively thinking of suicide:

Some sites are written by professionals; several are heart-felt appeals to keep on having hope by people who have been suicidal: [Lollie.com](http://www.lollie.com/blue/suicide.html) (<http://www.lollie.com/blue/suicide.html>), [If You are Thinking about Suicide](http://www.metanoia.org/suicide/) (<http://www.metanoia.org/suicide/>), [Suicidal.com](http://www.suicidal.com/) (<http://www.suicidal.com/>), or if you don't feel like

reading, look at the little piece at [Depression Bookstore](http://depressionbookstore.com/bookhelp.html) (<http://depressionbookstore.com/bookhelp.html>). If you are gay, see [Youth Suicide Problems-Gay Bisexual Male Focus](http://www.virtualcity.com/youthsuicide/) (<http://www.virtualcity.com/youthsuicide/>); for patient or family, see [Suicide Prevention Help](http://www.suicidepreventionhelp.com/) (<http://www.suicidepreventionhelp.com/>), and almost all college students should expect their Counseling Center or Health Center to respond immediately to a suicidal student. If they do not answer the phone, call a Resident Assistant or Campus Police.

Online information for Survivors--friends and relatives living through someone else's suicide

General information, articles, news releases, research support, professional organizations; government organizations: [American Association of Suicidology](http://www.suicidology.org/) (<http://www.suicidology.org/>); [NIMH National Strategy for Suicide Prevention](http://mentalhealth.samhsa.gov/suicideprevention/) (<http://mentalhealth.samhsa.gov/suicideprevention/>); [CDC National Center for Injury Prevention and Control](http://www.cdc.gov/ncipc/factsheets/suifacts.htm) (<http://www.cdc.gov/ncipc/factsheets/suifacts.htm>); [SA/VE—Suicide Awareness/Voices of Education](http://www.save.org/) (<http://www.save.org/>) concentrates on depression and suicide; for useful material written in several languages see: [Befrienders International](http://www.befrienders.org/) (<http://www.befrienders.org/>); Samaritans (jo@samaritans.org) are known world wide for their suicide prevention services, mostly in Britain, Scotland, and Ireland (email from anywhere is possible). [Mental Help Net-Suicide](http://mentalhelp.net/poc/view_doc.php?id/498/type/doc/cn/Suicide) (http://mentalhelp.net/poc/view_doc.php?id/498/type/doc/cn/Suicide) discusses symptoms, online resources and support, and organizations dealing with suicide. Similarly, [PsychCentral's Suicide Helpline](http://psychcentral.com/helpme.htm) (<http://psychcentral.com/helpme.htm>) lists many suicide helplines and self-help groups dealing with surviving a loved one's suicide.

Other sites educate and help train counselors, parents, reporters, researchers, etc.: [SIEC-Suicide Information and Education Center](http://www.suicideinfo.ca/csp/go.aspx?tabid=1) (<http://www.suicideinfo.ca/csp/go.aspx?tabid=1>) provides information, training and help doing research. Also helpful with training and research is [Center for Suicide Prevention](http://www.suicideinfo.ca/) (<http://www.suicideinfo.ca/>). [Keep Yourself Alive](http://eric.ed.gov/ERICWebPortal/Home.portal?_nfpb=true&_pageLabel=RecordDetails&ERICExtSearch_SearchValue_0=ED431980&ERICExtSearch_SearchType_0=eric_accno&objectId=0900000b80098373) (http://eric.ed.gov/ERICWebPortal/Home.portal?_nfpb=true&_pageLabel=RecordDetails&ERICExtSearch_SearchValue_0=ED431980&ERICExtSearch_SearchType_0=eric_accno&objectId=0900000b80098373) aids Australians with suicide prevention and guides the media, underscores the association of mental illness with suicide, and coping with death. [American Academy of Child & Adolescent Psychiatry](http://www.aacap.org/publications/factsfam/suicide.htm) (<http://www.aacap.org/publications/factsfam/suicide.htm>) publishes an article for parents concerned about suicide. Two more Sites provide news, articles, books: [Suicide and Parasuicide](http://www.suicide-parasuicide.rumos.com/) (<http://www.suicide-parasuicide.rumos.com/>) or <http://www.borderlinepersonality.ca/parasuicide.htm>) and [Suicide and Suicide Prevention](http://www.psycom.net/depression.central.suicide.html) (<http://www.psycom.net/depression.central.suicide.html>). Lastly, there is a Web Site that focuses on the special case of homicide-

suicide: [Violence & Injury Prevention Program](http://www.fmhi.usf.edu/amh/homicide-suicide/)
(<http://www.fmhi.usf.edu/amh/homicide-suicide/>).

I will repeat a warning: some Web sites may be harmful. For example, one Web Site quotes many heart-wrenching comments written by people approaching or in the midst of suicide; it also provides a questionnaire for assessing the lethality of one's current suicide tendencies; it is an emotionally touching, possibly helpful, thought-provoking Site by a very experienced psychologist, Fred Cutter, but I decided to not cite it. In another Web Site, a nurse clearly intends to discourage self-injury by describing unintended and horribly failed suicide attempts resulting in brain damage, life-long disability, etc. Other sites with less helpful intentions describe self-inflicted death in gruesome detail, as in the Japanese military during WWII. Many non-professional Web Sites, forums, lists, and chat groups are, of course, very supportive and helpful but a few occasionally encourage suicide very inappropriately. On the whole, support groups are a great benefit and quite safe but there are misguided posters and mishaps, so be careful. It is not known how the people in the depths of despair respond to highly emotional and/or unhelpful literature or Web Sites. Some relatives have believed that certain sites have caused serious consequences and they have sued.

There are memorial sites: Web Sites where young people, loved ones, and others are mourned by their mothers, fathers, spouses, siblings, and others. Schools have constructed "grieving gardens" for students who have died, including plaques to ones who have killed themselves. However, the wisdom of some of these memorials and sensationalized reports in the media are questioned. See *The Copycat Effect* by Loren Coleman (2004). And there are other topics I haven't covered, such as physician assisted suicides (Rosenfeld, 2004). See books below.

Books for anyone in the midst of choosing to live or die:

Ellis, T. E. & Newman, C. F. (1996). *Choosing to live: How to defeat suicide through Cognitive Therapy*. New Harbinger Publications.

Books for the people who survive a loved one's suicide ("Survivors")

Living though a child's or a loved one's suicide is a devastating experience. Sue Chance (1992), a psychiatrist, describes how her family survived her son's suicide. Another mother (Carlson, 1995) tells how she coped and offers help to others. Grollman and Malikow (1999) offer help in understanding suicide—how the victim might have felt and why it happens—and in coping with the grieving process. Colt (1991) and Marcus (1995) cover all aspects of suicide--its prevention and coping with it. Wroblewski (1994) has written a highly recommended guide for the survivor.

When suicide happens close to us, we wonder why. This is doubly hard to understand when serious mental illness is part of the picture: Kay Redfield Jamison (2001) suffered a bipolar disorder and was suicidal from her teens to her thirties. Yet, she became a psychologist, gained knowledge about suicide, and wrote an excellent book to help us understand the bipolar illness. Similarly, a grieving father of a 23-year-old suicide victim searched exhaustively for the reasons his son suffered mental illness, many suicide attempts, and many defeats (Aurthur, J., 2002).

See Norcross, et al (2003) for more recommended books, film, Web sites and support groups.

Books for therapists:

Pope and Vasquez (1998) have an excellent chapter for therapists treating suicidal patients (<http://kspope.com/suicide/index.php>). It can be a very trying and stressful experience for the therapist and, if the patient dies under his/her care, it is traumatic, often involving both great personal grief, like the loss of a close friend, and sometimes guilt and deep regrets. The chapter gives several suggestions for evaluating suicide risks and it discusses special circumstances when dealing with a patient threatening suicide. Of particular interest are bits of wisdom and the best advice from several recognized suicide experts.

Spirito, A. & Overholser, J. (2002). *Evaluating and treating adolescent suicide attempters: From research to practice (Practical resources for the mental health professional)*. Academic Press. Strong on assessment of high-risk young people and detailed information about dealing with specific circumstances and personality types.

References from this section are located in the book's bibliography (see Table of Contents). CTL Last updated June 13, 2004.

Self-injury

Even though I thought I was a well trained therapist, it took me a long time to learn about self-injury or self-mutilation. Little or nothing was mentioned about it in Graduate School. At my first job in a Medical Center Psychiatry Clinic we treated women from a near by Women's Prison and a Girl's Reform School. Occasionally, one of those clients had carved her initials and/or a girlfriend's initials into her arm or stomach. It was a declaration of friendship and loyalty to another prisoner. A few years later, when I was consulting to a State Mental Hospital, I heard about patients who had deeply scared their face and a couple of men who had attempted self-castration. So, the young women from prison were expressing a positive feeling for someone else but the patients in a mental institution were expressing self-hatred.

It wasn't until I had published this book online in 1997 and was active on Forums in [Mentalearth: Self-Help and Recovery from Self-Harm](http://mentalearth.com/) (<http://mentalearth.com/>) (you have to register first and please abide by the rules) that I learned that self-

injury occurs among distraught anxious and depressed but functioning, educated women. They taught me that self-injury can serve other purposes, such as reduction of distress. Since then I have read in recent publications about similar motivations. One of the most detailed and readable articles about self-injury is in [Look Beyond the Scars: Understanding and Responding to Self-Injury and Self-Harm](http://www.nch.org.uk/information/index.php?i=136) (<http://www.nch.org.uk/information/index.php?i=136>). This 2002 study interviewed in depth 24 self-injurers from all over England. I have relied quite a bit on their impressive report.

Painful life circumstances can lead to self-produced pain

In the kinds of self-injury cases I am concerned with here, there frequently is some very hurtful and disturbing condition in which the tendency to self-injure develops. You don't usually start with a method to hurt yourself; you start off with horrible circumstances and psychologically painful thoughts. A very wide variety of distressing circumstances and feelings precede intentional bodily injury—here are some examples:

Young people are sometimes emotionally abused and told they are bad, sinful, selfish, hurtful, hateful, uncaring, crazy, or weird. They may be blamed for their parents' troubles or divorce, etc. It isn't surprising they may end up feeling guilty, shame, self-hatred, and wanting to hurt or punish themselves.

Some have grown up in physically and sexually abusive families (beatings, threats & torture) and were called useless, stupid, ugly, slut, and a total failure; many were bullied by peers; some were raped. Some responded with resentment, intense anger, and repressed rage; others adopted the negative evaluations and felt worthlessness, felt no one could ever care for them, and felt like a piece of trash. Some responded to being hated with a defiant attitude, e.g. "you can't make me change" or "I deserve to be abused but I can hurt myself more than you can." Some wanted get back at the abusive person by hurting themselves via self-mutilation, i.e., showing visual signs of their feelings. Some physically responded to pain, punishment, and self-punishment by actually feeling better, something like having an adrenalin rush or taking drugs; others found that burning or cutting themselves numbs them to pain.

Others were feeling depressed, helpless and hopeless or were without feelings, almost like being dead. Some responded to self-injury while feeling dead with "The self-abuse showed me that I could feel and was alive." Others felt alone, uncared for, scared, sad, not just neglected but utterly worthless, rejected by family and friends, placed in foster care, dumped by boy/girlfriend, etc. so, it felt better to hurt themselves and, in that way, escape the hurt from others. Many were well aware they had seriously disabling psychological problems and felt weird, unable to cope, scared, helpless, and inferior. Still others felt out of control, couldn't do anything right, but were reassured by the courage they had when self-cutting, surprised at what injuries they could force themselves to inflict. Also, some developed an eating disorder which countered the helplessness feeling; it meant "I can control something (eating, not eating, and throwing up)." Some had heard about self-injury from others and were impressed with their willpower.

This list of stresses is not exhaustive but it illustrates the kind of psychological-emotional conditions that set the stage for the development of self-injury reactions. Soon we'll see how that might happen.

Self-Injury varies in severity and serves very different purposes

It should be made clear, however, that not all people who Self-Injure start with a terrible traumatic crisis. Some may have simply had friends or relatives who injured themselves and learned the behavior that way. Others who self-injure may have developed an unhealthy habit that helps them calm down: something like having a drink, eating, or smoking cigarettes or dope. In these kinds of cases, the injuries were not life threatening, maybe just a compulsion like pulling out hair, picking at sores, or sticking or hitting themselves. This self-abuse may be a distraction, a way to release tension, to regain some sense of control over a situation, or to show others that they really are hurting. Note: People who injure themselves do *not* necessarily have a mental health problem, especially if the physical damage is mild to moderate. For example, in a sample of about 2000 ordinary military recruits (60% males) about 4% had a history of self-harm. That 4% scored higher on anxiety, depression, borderline, schizotypal, dependent, intense emotions, and fear of interpersonal rejection (Klonsky, Oltmanns & Turkheimer, 2003), but not high enough to keep them out of military service.

On the other hand, it is fairly common for Self-Injury to be combined with various psychiatric diagnoses. Therefore, to understand this behavior in some people it is important to realize comorbid disorders may be involved, including: Depressive Disorder, Borderline Personality Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Attention Deficit Disorder, Dissociative Disorder and others (see [Diagnoses associated with Self-Injury](http://www.palace.net/~llama/psych/diag.html) at <http://www.palace.net/~llama/psych/diag.html>). Most of these additional diagnoses have a center core of intense emotions, impulsiveness, and irrationality. In addition, a different kind of self-injury occurs in the repetitive head-banging of autism and retardation. The most horrific mutilation, such as cutting off a limb, an ear, or self-castration, is usually in a very severe psychotic condition. So, self-injury may range from a mild habitual coping technique to death or an extreme response to overwhelming stress.

Major Depression and Borderline Personality Disorders

Certain diagnoses have been studied because they are associated with frequent self-injury and suicidal behavior, namely, Major Depression and Borderline Personality Disorder. One study (Brown, Comtois & Linehan, 2002) distinguished between suicidal self-injury and nonsuicidal self-injury in 75 Borderline women (over 50% were also diagnosed as having depression or anxiety). The patients were about 30 and had self-injured an average of 6 times in the last year, so they were quite injury prone. The women who inflicted nonsuicidal injuries gave these reasons: (a) to produce some feeling (relief, a sense of control, an emotional high), (b) to express their anger, (c) to punish themselves, and (d) to divert their attention from painful situations or thoughts. The main reason for self-injury given by the suicidal patients was "was to make things better for others." That is interesting but you can be sure it is more complicated than that. They all wanted to reduce internal stress.

Another study of suicidal self-injury in Borderline Personalities attempts to clarify certain differences between potentially lethal behavior in people suffering Major Depression and those with Borderline Disorders (Gerson & Stanley, 2004). Seriously depressed patients usually seem to be suicidal out of a deep sense of despair or self-disdain and seek the nothingness or peace of death. If their suicidal efforts fail, depressed patients may become even more depressed, hopeless, guilt-ridden, withdrawn and lethargic. Gradually, if treated with medication and psychotherapy, they usually become less suicidal in time. In contrast, the Borderline patient (70% have self-injured) becomes suicidal more quickly in response to changing circumstances or relationships and they report feeling better soon after the self-injury. This is more in keeping with their impatient, impulsive personalities. Starting in late adolescence, they often cling to others but have problems with dependency and anger control, so their relationships may become highly emotional and unstable.

A major problem here is that Borderline personalities, who often self-injure in order to regulate their strong, rapidly changing emotions, run a serious risk of unintentionally dying because they underestimate the risk of death in self-injury. Their therapists may also underestimate the risk, believing (correctly) their Borderline patients do not *intend* to kill themselves. Research has documented that single acts of self-injury are rarely lethal but when repeated over and over self-injuries can become a serious risk. Be aware. About 10% of Borderline patients eventually die by suicide (Paris, et al, 1987). A cognitive-behavioral therapy, Dialectical Behavior Therapy, has been developed specifically for Borderline Personality Disorders (Linehan, 1993).

The creation of paradoxical behavior

Most of us hate pain and do all we can to avoid hurting ourselves—our bodies have powerful reflexes and natural mechanisms to avoid injury and pain--the sight of our own blood flowing out of a cut is alarming to most of us. Some of the consequences of self-injury to some people are not what you would expect, namely, it can be an escape or venting mechanism, it may release built up emotions of anger, self-hatred, badness (blood letting can be seen as “letting the badness flow out of me”). Also, a dramatic self-injury can stop the downward spiral of depressive thoughts. Other people discover that the process of inflicting self-injury and pain takes their attention away from the most disturbing thoughts. So, some people simply learn they can produce pain or a shocking injury that distracts them from depression, guilt, anger, and worrisome obsessions. As a result, some might start to self-injure repeatedly, ironically, to feel better (to come out of a terrible emotional slump). This may seem odd, but it will not be surprising to people familiar with the concept of negative reinforcement (see chapter 4) in which the payoff or powerful reinforcement following some behavior is escape from an unpleasant situation. Reinforced self-injury can become a compelling habit.

Here is how one girl described her self-cutting from 13 to 16: “I was bullied and teased about my weight for two years and I couldn’t stand it any more. I became so angry with my body that I tried to commit suicide just to punish myself. I wanted to cut my wrists but couldn’t do that, so I cut my arms instead. I was calm as I did it. It felt I was finally in control of my life. It was a relief. The pain was intense but I focused all my attention on it. It proved I was still human and had feelings. From that first time, cutting became my preferred way to release feelings. When I got upset or angry, I’d just go to my room and cut with a razor or a sharp knife, then

clean up the blood and wear long sleeves. I got to the point that I was cutting every day, it felt like I was an addict. I got a high cutting, a real buzz. But I also hated myself for doing it and I got scared as it became dangerous. Eventually, my Dad saw the scars and took away my knives and razors. It was terrible when people at school found out. They watched me and asked me why I did it. I really wanted to die then and took a big overdose. I've been in treatment at Mental Health ever since. I'll be graduating in 6 months; I'm doing OK in school. I'd really like to be a journalist."

The selection of a method—injury or suicide?

Just as there are many causes of psychological pain, there are many ways to self-injure. Perhaps the most common method is self-cutting, most often on the arm. Another method is taking an overdose, i.e., taking drugs until you get sick or even lose consciousness, such as drinking until you pass out. Note: the kind of harm done in self-injury attempts is usually different from suicide attempts. Firing a large bullet into your brain or jumping from the tenth floor is definitely suicidal. Cutting your arm or foot is not a common method for suicide but it is a common method to relieve the emotional hurt one is experiencing or to let others know they are very unhappy. Some methods may serve either purpose, e.g., taking an overdose of drugs is a common method for both self-injury and suicide. Besides cutting and overdosing, self-injury includes burning yourself, hitting a wall, jumping from somewhat high places, hitting yourself, self-choking, and sometimes getting others to hurt you. Most self-injury victims clearly differentiate in their minds between self-injury and making a suicide attempt (most self-harmers have had thoughts of suicide in the past but at any one time the intent is usually clear). People wanting to self-injure may, of course, miscalculate the risks (and they are well aware of possible errors) but they often think of self-injury as a way of relieving their extreme emotional distress and, thus, *reduce* the chance of dying right now. I don't want to imply that the distraught self-harmer *always* has a clear intent in mind—to die or not to die. There are people who injure themselves seriously and are willing to leave the outcome up to chance or fate or to whatever powers they believe in.

To those of us who have never experienced the absorbed obsession associated with intentionally injuring our bodies and have never gotten emotional relief in that way, the whole idea may seem incomprehensible and, frankly, rather grotesque. One's first thought may be that this is a thinly veiled suicide attempt; i.e., they are really trying to kill themselves but won't admit it. But as we understand the situation better, we realize that for many self-abusers the act is self-protective, not self-destructive. They don't want to die. They want to deal with their troubles and unhappiness; they would like to find more constructive and effective ways of escaping psychological pain instead of self-injury. But until they discover better ways of coping, when they feel painfully distraught, the urge to self-injure returns. My Self-Help Forum friends helped me understand that situation. I appreciated that.

Like so much human behavior, self-harm is, at first, hard to understand. Each victim of self-harm is unique, has a different history, a different set of personal problems, and a different means of hurting him/herself. There is sometimes a well remembered and understandable original experience with self-injury followed by a long history of using similar self-injury techniques over and over. A therapist may believe (I think wisely) that the therapeutic task is more to develop some effective methods for dealing with the currently overwhelming emotional troubles rather than

to analyze at length the childhood dynamics and reasons for starting to self-injure. But both routes might work.

How rare is self-injury?

There are few studies of the frequency and nature of self-injury. One study (BMJ, Nov., 2002, Volume 325, pp 1207-1211) of 6000 British 15 and 16-year-olds reported that 7% had deliberately hurt themselves sometime in the past (only 1 in 8 of that 7% had hurt themselves seriously enough to go to a hospital). Another large study of teenagers reported that more than 10% had cut themselves sometime in the past. Hurting yourself may start at any period of life (as early as 6 or 8) but most commonly it starts in the turmoil years of 11 to 14. Wendy Lader, author of *Bodily Harm*, estimates that 1% of Americans use self-injury to deal with emotional distress but she says the rate is much higher among teens, especially females. Why more females? Supposedly, according to Lader, partly because females tend to react inward when upset rather than outward—they would rather hurt themselves than someone else and, besides, openly going into a rage isn't a very feminine thing to do.

Among people who have this tendency, how often do they self-injure? A few people may hurt themselves every day, e.g., pull out hair or pick at a sore, but more typically, say with cutting, it may be every few days. Quite often there are several injuries close together and then a break for perhaps weeks or months. Such an irregular schedule makes it hard to know if you have finally stopped hurting yourself or not.

Other causal factors involved in self-injury

Personal characteristics and environmental circumstances sometimes set the stage for self-injury. For instance, people who observe or hear about self-injury very often think of the self-abuser as mentally disordered. This social perception could well contribute to the self-injurer having low self-esteem. And low self-esteem increases the risk of self-injury. The 2002 BMJ study mentioned above found that young females hurt themselves four times as often as males. For young women, the risk is increased if they have had family members or friends who self-harmed, been very depressed or anxious themselves, had low self-esteem, had abused drugs, or were impulsive. For young males, high risk situations included having suicidal friends and relatives, using drugs, and having low self-esteem.

We have seen that self-injury usually starts while a person is extremely upset; then in a fit of anger or self-hatred or depression or a feeling that everything is going wrong, the person hits the wall or cuts him/herself or puts a cigarette out on her/his arm...and finds the intense emotional stress is relieved. This experience—actually the emotional *benefits* of self-injury--is remembered and may be used again whenever the stress becomes intense again.

Often, just the open, intense expression of feelings cleared the air and resulted in lessening of the stress. In some cases, the person clearly felt guilty—felt they had been bad—and the self-injury took the form of self-punishment. For others, it wasn't self-punishment at all, but it just felt good to escape the hurtful feelings or to discharge their intense feelings. After emoting, some felt they were finally communicating and being heard; however, it would be a mistake to dismiss the

expressions of genuine feelings during self-injury as being merely attention getting behavior. Indeed, most self-injury is done in secret and kept secret. Yet, it can be a cry for help. And why not? Most self-abusers feel that no one understands them and no one cares.

The reactions of others to self-injury

Some people become concerned that a person who is so angry that they self-injure is dangerous to others. It is true that some self-injurers are angry with others, but they seem to usually cope with aggression by turning it on themselves. Professionals do not ordinarily consider self-injurers to be a risk to others. Of course, if the self-injury behavior begins to include aggressive acts, such as bullying or physical threats, then one would rightly have concerns about the welfare of others too.

Naturally, friends or relatives are often upset by this behavior and bluntly urge the self-abuser to stop. Some people who self-injure feel some resentment of this and think “if my hurting myself doesn’t bother me, why should other people be concerned? What’s it to them?” The answer is that watching or even hearing about self-abusive behavior is troubling to most people, especially if it could be permanent or lethal, if the aggression might extend to others, and if the observers do not realize that self-injury can be a method to allay the overwhelming stress. Most self-abusers, however, in the course of time, feel that they would like to avoid using self-injury as a coping mechanism. If they can find other ways of soothing their emotional turmoil, the self-injury response will extinguish.

Other people—friends, partners, and relatives—often at least have negative feelings about self-injury; it doesn’t immediately arouse sympathy. Instead, it often causes a conflict situation where the self-abuser is criticized and called weird or crazy. Even experienced therapists may not have dealt with much self-injury before, so like others, they may be baffled by it. Besides, young people often do not take kindly to the comment that “you need to see a shrink” which is said more like an order or a demand, rather than gentle concerned encouragement.

How should one respond to a person who self-injures?

The simple answer is: with concern and respect, with a desire to understand and help, with no criticism, blame or negative comment. Some self-abusers appreciate getting to talk about their troubles, their feelings, and even their self-injuries. Others feel they have been misunderstood, mishandled and neglected before, so “let’s not talk about it.” Sometimes they get tired of telling the same history over and over without getting help; sometimes they have been told that therapy will not be provided if they continue to self-injure (doesn’t seem empathic, does it?); sometimes their helpers just seem uninterested, treat them like a child, or appear to have little time. If these are the kinds of experiences self-harmers have had in the past, naturally if you are a newly assigned helper, they are not going to warm up to you right away. It takes a little time and a lot of genuine concern. They do want help.

In most cases, however, self-injurers feel they were or would be helped by support groups made up of other self-harmers. They don’t believe that more statistical or diagnostic information about self-harm (in the form of the typical brochure in the doctor’s office) would help them very much but they are interested in

ways of coping. Self-injurers often find that the agency service personnel and staff need more information about self-injury.

If you are a parent or a spouse of a self-abuser who also seems to be over-emotional, impulsive, unreasonable, provocative, and/or uncontrollable and is driving you crazy, she or he may have a Borderline personality. If so, get the book, "Stop Walking on Eggshells" by Mason, Kreger, & Siever (1998). It may help you understand your loved one and be less upset by his/her roller coaster behavior. You need to take care of yourself and not get sucked into the loved one's turmoil.

How do people stop hurting themselves?

I must emphasize again that self-injury is both psychologically difficult to understand and dangerous to one's health. Therefore, an important and wise first move is to get professional help. I will mention self-help techniques but please seek therapy with an experienced, well trained practitioner.

WARNING: the following self-help methods, while intended to be helpful, may be described in some details that could trigger a self-injuring response. If you are in a mood to self-harm or if you are responsive to triggers, please do not read this section. If you are unsure of your self-control, please discuss how to reduce self-injury with your therapist soon.

The 2002 British study says the general answer about how people stop self-harming behavior is they start feeling better about themselves. How do they achieve that? They get their life in order...somewhat. If they are completely "down," they find a place to live, a way to get food, a place to take care of their kids--real basic stuff (the threat of losing their children is a major stress...and motivator). They work through some of their intense feelings from the past and become more able to communicate with others, both to express things they don't like and to relate more positively. Generally, among the very poor and disadvantaged in Britain, finding a supportive environment (living conditions and helpful friends) was a crucial step towards achieving an acceptable adjustment.

In their personal lives, some of the subjects in the British study who had reduced or quit self-harming had made use of self-help methods, e.g., a few had switched from hurting themselves to a somewhat controlled smashing of things, like breaking glassware or hitting objects with a bat. Others had substituted using alcohol or drugs to relax or distract themselves instead of self-injury. Another approach is to cause pain in some less objectionable way, such as flipping your wrist with a strong rubber band or holding your hand in ice water or maybe just holding an ice cube. A few people can substitute an imagined injury for an actual injury, e.g. by just thinking about cutting yourself or maybe marking with a red marker the place on your arm where you might cut and where the blood would flow, if you did it.

Instead of bodily hurting themselves, some people can vent their anger with physical exercise, e.g., do some real hard work, mow the lawn, lift heavy furniture, squeeze a pillow hard, workout at a gym, and in some of these ways feel less need to feel pain.

Breaking the chain of events early is possible (see chapter 11). Some had learned to detect early a troublesome downward train of thought leading to self-

injury, and then they learned to consciously focus on distracting thoughts, such as watching TV, listening to music, taking a nap, or reading a magazine or book. Still others found the chain of thought leading to more serious depression or self-hatred could be broken early by talking to supportive people, calling their therapist (or just thinking about topics for the next session), or posting to an online self-injury group (or imagining the conversation at the next support group meeting). Also, a few found interesting activities to do, like relaxing and meditating (see chapter 12), going shopping or for a walk or a workout, writing their life story (see chapter 15), or doing drawings or art work to express their feelings.

More self-help ideas

Make a serious effort (it will take therapy or weeks on your own) to understand these awful feelings that start and generate this whole process. Ask: "Why am I feeling so awful?" "Are my thoughts and feelings reasonable? If not, what unreasonable beliefs do I have that give me such a heavy emotional load and sap my self-esteem?" "How can I change these feelings and get a more realistic view?"

During some good times, prepare a list of things in your life that you appreciate, really enjoy, value, and feel grateful for. Use this list (keep it updated) as a handy reminder when depressed that there are good things in your life as well as bad things. Be sure to include your good traits, talents, good deeds, assets, beautiful parts, etc., showing you aren't as bad as you sometimes think you are.

Procrastinate doing self-injury. Tell yourself to put self-criticism or self-injury off until later—"maybe tomorrow." Most impulses lose their urgency when you put them off...especially if coupled with keeping your mind on other things. The need to feel pain will diminish also because the deep depression, self-hatred, guilt or whatever has declined.

The environment is a powerful determinant of our behavior (see chapters 4 and 11). Hide away stuff you use to self-injure. Stay out of the room, chair, sink, or situation you usually hurt yourself in. Don't go there mentally or physically. If you are "triggered" somewhere (a room, a TV show, a book, a discussion, an idea), quickly get out of that situation and think about other things.

Develop a routine to easily use when feeling especially bad—nurture, even "baby" yourself. Perhaps go for ice cream with a friend, take a long, warm bath, look at especially selected pictures of good times and people you love, play with a pet, develop special activities with your family, enjoy a nice romantic/erotic story, etc.

Sometimes people find it helpful to sign an agreement with someone to not self-harm without calling them first. For very distraught times, however, the contract may not be a strong deterrent.

The above methods have worked for at least a few people. No one method works for all people who self-injure. The methods that work are usually tailored for a specific person. I hope this long list helps you believe that you too can devise several techniques that might guide you away from deep depression and/or self-injury. Then try them out.

Changes needed in psychological services: Look beyond the scars

The British study group that I have cited several times found major deficiencies in professional care for the people who self-injure. I believe the situation in the US is similar. First, our institutions provide the same services for suicide and for self-injury, namely, medication and hospitalization or out-patient treatment. But people who self-harm see traditional psychiatric hospital treatment as poorly understanding their needs (often negative and dismissive) and, thus, unlikely to give good service. Needed are specific facilities and trained staff that would provide understanding, respectful, caring "safe houses" for a day or a few days; counselors specializing in self-injury; education and counseling for children, spouses, parents or friends involved; self-help instruction and self-help support groups; special attention to child care while families are broken up; and so on.

Some of the available literature

The major search engines will fetch many Web sites providing information and concrete suggestions for coping with self-injury. Note particularly [PsychCentral](http://www.psychcentral.com/resources/Suicide_and_Crisis/) (http://www.psychcentral.com/resources/Suicide_and_Crisis/) and [Healthyplace.com](http://www.healthyplace.com) (http://www.healthyplace.com/Communities/Self_Injury/Site/index.htm). Other Web sites provide support groups, understanding articles, and suggestions for dealing with Self-Injury: [Self-Injury: You are NOT the Only One](http://www.selfharm.net/) (<http://www.selfharm.net/>) and [SIARI: Self-Injury and Related Issues](http://www.siari.co.uk/) (<http://www.siari.co.uk/>). Self-help methods useful with self-injury are described in [Stopping Self-Injury](http://www.self-injury.net/stopping/) (<http://www.self-injury.net/stopping/>) and in this article, [Self-Inflicted Violence: Helping those who Hurt Themselves](http://www.selfhelpmagazine.com/articles/depress/violence.html) by Tracy Alderman (<http://www.selfhelpmagazine.com/articles/depress/violence.html>).

Two large Web sites cite many articles and review over 75 books in this area: [Home-Health-Conditions-Self-Injury](http://www.geometry.net/health_conditions/self_injury.php) (http://www.geometry.net/health_conditions/self_injury.php) and [Self-Injury Books](http://www.soulstreet.org/bookstore.html) (<http://www.soulstreet.org/bookstore.html>). There are a surprising number of books in print about this topic, a couple by Clinical Psychologists and therapists: Alderman (1997) and Levenkron (1999), one by three therapists who recommend extensive inpatient treatment (Conterio, Lader & Bloom, 1999), another by a psychiatrist (Favazza, 1996), and two by journalists who interviewed people with this compulsion (Hyman, 1999) and (Strong, 1999). Any of the books can help you become aware and empathize with a self-harmer but I'd suggest one of the books written by a professional. Certainly keep in mind Dr. Linehan's (1993) book for self-help methods.

Loss of a relationship: breaking up; estranged from parent

The second most intense life stress, after death, is divorce or loss of a love relationship. Most of us beyond 14 or 16 have felt the intense pain and anguish of being rejected by a lover. Many writers have dealt with marital problems and the long, distressful process of divorce. Kessler (1975) described seven stages of divorce:

Stage 1: Disillusionment

After the bliss of falling in love (with the ideal person for you), a new idea sneaks into your mind: your lover has some faults. You may begin "psychologizing," e.g., "he is very self-centered," "she is nagging like my mother," "he flirts with women to hide his sexual fears," "she gets a lot more involved with the children than she does with me," etc. If these feelings grow in either person, without being resolved, the relationship is in trouble.

Stage 2: Erosion

The disappointments and fault-finding reduce the love and attraction. They may not know what is wrong or what to say. If the relationship is becoming a little strained, this is the best time to have a good, straight talk or to seek marriage counseling. If no changes are made, a lot of destructive interactions may take place: put each other down, compete for attention, spend money carelessly, find new interests, watch each other critically, avoid each other, stop "confiding" or having sex.

Stage 3: Detachment

Each disappointment hurts. "Love dies a thousand deaths." Lovers pull away to avoid hurts and sadness. If the isolation continues, it becomes more and more difficult to return to being lovers. Sometimes only one person is in the detachment stage; that is enough to kill the relationship. In this stage, the couple share and talk little, imply that "I don't care" even though they're hurting, and begin to think of other possible partners. They can't decide to leave or not. Often anger sets in--anger makes it easier to decide to separate.

Stage 4: Physical separation

Separating is a sure sign the relationship has failed. Before, you might say, "we aren't getting along; we're fighting a lot," but now the relationship is gone--lost. There are many reactions to separation: often it is a painful, crushing void, sometimes if you have wanted out for a long time it is a relief, usually there is loneliness, fear, and feelings of failure. There are many adjustments to make--new place to live, new routine, new people, etc.

Stage 5: Mourning and letting go

We mourn the loss of a partner, even one who has caused us pain. It is the loss of a dream, if nothing else. We rid ourselves of the "ghosts" of our past love, give up hope of reconciliation, and realize the ex-lover is gone forever. Usually there is a mix of intense emotions: sadness, anger, guilt, fear, hope. Often we spend hours reliving the old relationship--how awful he/she was, how it should have been, whose fault it was, etc. The person needs to "work

through" these old emotions. Eventually, he/she will decide to get on with his/her life.

Stage 6: A new life.

The focus shifts from the past to the future. Sometimes there is even an obsession with a new interest or life-style--new clothes and looks, drinking, seducing and partying, or complete involvement with work and planning a new career or volunteering to help in some social-political movement. Some are eager to find love again, others hate the opposite sex, others are scared of emotional involvement. In some ways it's like being a teenager again.

Stage 7: Healthy adjustment

With luck, one emerges from a broken relationship wiser, tougher, stronger, and mellower. You have found some good friends and made reasonable plans for the future. You are no longer so worried you can't sleep at nights and, although life is hard, you are ready to move on to something better.

Each person is different. Some skip stages; some get stuck in a stage; some slide through the stages quickly and silently. Seldom does a divorcing couple start and go through the same stages at the same time. The earlier a couple attends to problems, the better. It is an unending task of true lovers to be sure the fun and affection outweigh the boredom and resentment. If you are stuck in stage 2 or 3 for a few weeks and can't work it out or get your partner to seek counseling together, go by yourself. If you are still mourning a former relationship (that obviously had problems) after more than two or three months, seek some help with speeding up the recovery process.

I have counseled many young people in the depths of agonizing depression following a break up with a boy/girl friend. Many felt the situation was terrible, almost unbearable (see cause #6 above). Indeed, some had thoughts of suicide. Yet, in my classes three-fourths or more of the students have broken up with someone they thought at the time was *the best partner they could ever find*. But, when I ask if that expectation has thus far proven to be true (that they couldn't find anyone as good), less than 5% say yes. There is an inexhaustible supply of people to love. It is a cruel hoax to imply that there is only one person for us to love. So, should you leave a strained relationship without regrets and pain? No, there is another way to look at it.

Feeling terribly upset when losing a lover may be hard but desirable. After listening to the pain for hours, I have often asked a person who has just been rejected, "How would you rather react to such an important loss?" The point is: your sadness comes from your good traits--you were loving, devoted, caring, committed, trusting, and involved. You had given your whole self to the relationship. Isn't that the way you want to be? Isn't that the way you want your future partners to be? Would you really want to be so self-centered, so

uninvolved that you could easily dismiss a love relationship? So, bear the unavoidable grief for a few weeks, then get on with building a future.

It is commonly said that the cause of a break up or divorce is shared, that it's 50-50. That isn't necessarily so. It may be largely one person's responsibility--their needs, personality, irrational ideas, or emotional problems. It may be neither's responsibility; they may simply have different interests, values, opinions, life-style, etc. which are no one's fault. You don't need to assign blame, but it would be wise to understand what happened so the same problems can be avoided in the future. (Young children often blame themselves for their parents' divorce, how sad. Shaver and Rubenstein [1980] suggest this results in self-doubts and shaky relationships many years later.)

How can you help yourself through the loss of love? Stearns (1984) deals with getting through a crisis. Many books specifically address marriage problems (see chapter 10) and divorce or breaking up (Fisher, 1981; Bloomfield, Colgrove & McWilliams, 1977; Gettleman & Markowitz, 1972; Kranitz, 1987; Krantzler, 1972; Krantzler, 1977; McKay, Rogers, Blades, & Gosse, 1984; Phillips & Judd, 1978; Weiss, 1975). Make use of one or two. Broder (1988) focuses more on coping as a single adult after a divorce. Books for children are by Gardner (1971), Franke (1983), and Richards and Willis (1976). Bernstein & Rudman (1988) review several books for children suffering through a separation or loss. The pain of divorce on adults and children is dealt with more extensively in chapter 10.

Some advice by parts of the problem

Level I (behavior): Find a friend or two to talk to; really pour out your feelings. Accept the support offered by friends and family. Immediately put away all visible pictures, cards, clothes, anything that reminds you of the lost lover. You don't need constant reminders.

If you are still "down" after 3 or 4 weeks of post-divorce grieving, find more things to do, go places, have some fun. Some people want to avoid the opposite sex for a while, but other people find that the best way to forget an old love is to go looking for a better love. When you are stronger, say 4 to 6 weeks after separating, take all the reminders of the former partner, even the out-of-sight ones, have a good cry, say goodbye to them, and throw or store them away permanently. It is time to start a new life.

Level II (emotions): See the last section of this chapter and chapter 12. Desensitization or a "depression chair" may lessen the pain of remembering the past.

Level III (skills): Social skills, assertiveness, and decision-making skills may be helpful (chapter 13).

Level IV (cognition): Challenge the irrational thinking that leads to possessiveness and awfulizing (see cause #6 above and method #3 in chapter 14). Often, one person has trouble letting go during the break up. It is true that through marriage vows and thousands of soft utterances we pledge our undying commitment. We intended to love our spouse forever, but we can not control all our feelings; love can turn to indifference or hatred in spite of all our pledges. This is a reality that every lover must know, face, and accept. In life, being loved is a wonderful experience but it is not a "right" we can demand. We are not in control of love. Thought stopping (chapter 11) can reduce painful thoughts and fantasies.

Faulty conclusions abound when falling in love and scrambling out of love. We make the partner into a saint, later the same person may be seen as an ogre. If you still think the departing partner is so wonderful you can't live without her/him, make a list of her/his faults or liabilities. If he/she seems to be awful, remember his/her good traits and realize there are reasons for his/her meanness. Each partner will benefit from considering the possibility of finding a better relationship. Gradually specific plans for a better life should emerge for both people. You have loved and been loved; it can happen again.

Level V (unconscious factors): During the emotional turmoil of breaking off a relationship, sometimes hidden traits (in both people) are openly exposed, e.g. possessiveness, fear of responsibility or intimacy, self-centeredness, self-put downs or criticism of others, sexual self-doubts, irritating or self-defeating habits, and so on. To understand is to forgive. Insights into your own weaknesses can become self-help projects. The next relationship benefits from this growth.

Loneliness

We humans are social animals. If we are abandoned as an infant or young child, we first protest by screaming, then we quietly withdraw, and finally after about two weeks we become detached and apathetic. Abandoned, we will joylessly play with others some but there is no emotional involvement (Bowlby, 1969; 1973). As Rene Spitz observed 50 years ago, infants may actually die if they are not played with, talked to, held, stroked, and "loved." Some species of monkeys also die when abandoned by their mothers. Even brief separation of infant monkeys from their mothers causes them two years later to cling more timidly and relate more poorly. Perhaps one can die of a "broken heart" (Lynch, 1977). Social contact is a powerful need. About 20% of us are feeling lonely at any one time (Ostrov & Offer, 1980). Almost all of us are lonely sometimes. But 1 in 5 Americans do not have a friend with whom they could discuss a personal problem.

A few years ago Bob Greene wrote a column about the cruelty of children and described a shy 12-year-old boy who was given a card by

his classmates that said: "THE MOST UNPOPULAR STUDENT AWARD: ___\ (his name)\ ___." The kid was crushed. Mr. Greene got a tremendous response from his readers saying they remembered similar times in their lives 30 and 40 years ago. One man wrote, "...whenever I am feeling down, I realize that inside of me that little boy still lives: the little boy who sat alone at home because nobody wanted to play with him." Others recalled the deep hurt, intense pain, and self-blame that they felt when ostracized by more popular classmates. They felt so ashamed, they couldn't talk to anybody about it. Between 10% and 20% of all children and adolescents, especially the poor, are lonely a lot of the time, not just sometime during the month.

Loneliness is more than being alone. In fact, many if not most people enjoy solitude. Loneliness is missing and longing for some kind of human interaction (even if you are in a crowd or in an "empty shell marriage"). The kind of contact missed varies greatly, e.g. one could miss one particular person or one kind of social interaction (e.g. at work or old friends or emotional intimacy in a love relationship) or social activity in general. Indeed, some writers distinguish between *social loneliness*, which is not being part of a group of friends, and *emotional loneliness*, which is not being intimate with or able to depend on anyone. Aloneness can also be *spiritual*--a feeling of separation from God--or *existential*--an awareness of our individual separateness. All these forms of aloneness contribute to depression.

However, the Existentialists believe, as did Thoreau, that aloneness is the human condition--we are born alone, we alone direct our lives, and we, in the same sense, die alone. Sure, lives touch and even join for a while, but you remain a separate person. These therapists say being alone is important for gaining perspective and growth (Moustakas, 1961). Thus, they distinguish between loneliness, which is wholesome, and the fear of being alone. It is this scary dread of being alone and the feelings of emptiness that we are dealing with in this chapter. Some people are people addicts (see chapter 9); they can't stand to be alone. We need to be our own best friend, but you only get to know that "best friend" when you are alone--and not playing social roles.



I never found the companion that was so companionable as solitude.
-Thoreau



Keep in mind the radical changes in our society since Thoreau's day or when your grandparents and great-grandparents were young. Our dependency on people has increased enormously. A hundred years ago most Americans lived on farms and were very independent, perhaps seeing a neighbor once or twice a week and going to town to

shop every two weeks or so. In that situation, if the children were starving neighbors would give food, but if the children were beaten or kept home from school or "married off" at 13, no one would intervene. In those years the heroes were explorers, like Daniel Boone, and the pioneer settlers--rugged, self-reliant, "free" individualists. Today, no one is that independent. We are far more reliant on suppliers of goods, on governments, on service agencies, on police and courts, on social and church organizations, on schools, on friends, on TV and music, etc. As we become more and more dependent on other people, including on our families until age 22 or so, we are more needy and more likely to long for social contacts when none is available. We are unaware of our ever increasing dependency (see chapter 8). The struggle between the values of self-reliance (Republican) and governmental support (Democrats) continues to be a fundamental conflict in our political system. (I believe in self-help *and* in caring for needy others until they are independent, so which party should I support?)

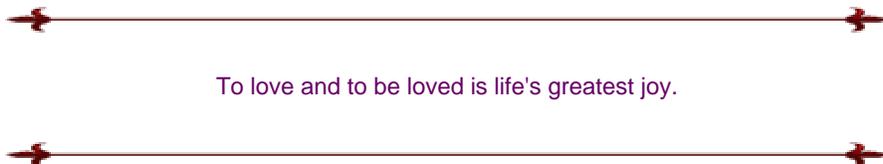
About 26% of college students report feeling "very lonely" during the last few weeks; over 80% of adults have been lonely (Flanders, 1976). What feelings are involved in being lonely? Rubinstein and Shaver (1982a) found four kinds of emotions: (1) desperation (helpless, afraid), (2) depressed (empty, self-pity), (3) impatient boredom (bored, angry, and restless), and (4) self-criticism (I'm ugly, stupid, and worthless). Loneliness seems to lower our self-esteem and low self-esteem seems to contribute to loneliness. It is circular... and both contribute to depression.

Why are we lonely? There are 100's of answers: we have lost a relationship; we feel unneeded and different from others; we are aggressive and bossy and drive people away; we are misunderstood; circumstances force us to be alone; we recently moved; we have unusually strong social or intimacy needs; poor family and peer relationships in childhood lead to loneliness; the discrepancy between what we want socially and what we get generates disappointment; a mobile society forces us apart; shyness, lack of social skills, and low self-esteem increase isolation; difficulty self-disclosing limits friendships; watching TV deepens loneliness; cultural values of competition and independence may isolate us; no close, personal relationship with God increases aloneness; the foolish but romantic belief that love solves all problems may increase loneliness. Let's discuss the last reason a little more.

Gordon (1976) thinks success in our society is defined in terms of having a "best friend" from 7-13, a "boy/girlfriend" from 13-23 or so, and a spouse ever after. In fact, our culture still encourages us to believe that romantic love and marriage will solve all our problems. Then, when we marry our "true love," we destroy our love by expecting too much of it. In the end, our partner can't meet all our needs, we have left our family and old friends behind, we have lost our dream and, now, aren't sure how to meet our needs. Research confirms that marriage isolates women (but not men) from friends,

and men (but not women) from confidants (Fischer & Phillips, 1982). The isolation from friends and confidants causes unhappiness.

If you ask people, "What contributes most to your happiness?", married people say: (1) being in love, (2) marriage and children, (3) the partner's happiness, (4) a job, for men; personal growth, for women, and (5) sex. For singles it's: (1) friends and social life, (2) being in love, (3) job, (4) recognition and success, and (5) sex. Conclusion: human contact, in some form, is vitally important to our happiness.



To do something about loneliness, you need to know the unique causes in your case. If a person says, "I can't make friends," what does that really mean? It could mean that no one is available in the current situation? Or, it could mean "I don't know how to do it--what would I say?" Or, it could mean "I know how but I just can't bring myself to do it--I'm shy and inhibited." Or, "I'm too nervous to do it--I'd fall apart and make a fool of myself." Or, "they aren't going to like me--I'm too dull and quiet." Obviously, these different answers reflect different assumed causes and outcomes (the real causes and outcomes may be different) and suggest different ways of handling the loneliness. Some causes seem more treatable than others; certain attributions (explanations) provide more hope than others.

When lonely and non-lonely students were asked to explain their interpersonal successes and failures, the lonely more often attributed their failures to a lack of ability and *permanent* character traits ("I'm dull and uninteresting") rather than poor strategy, lack of effort, their mood, or other factors. Therefore, they feel there is no hope. When Horowitz, French & Anderson (1982) tested the actual social skills of the lonely and non-lonely, they found the lonely produced fewer and poorer solutions to interpersonal problems. So, the lonely may be right when they say, "I don't know how to interact." But they can learn social skills.

Remember that underachievers were thought to be motivated to fail in order to avoid scary future responsibilities. Likewise, some depressed people appear to fail in order to avoid people expecting them to do something in the future. Now, there is a theory that lonely people, who also have a low opinion of themselves (extensive research documents low self-esteem, shame, and self-blame), are strongly motivated to avoid contact with others. Why? *So they will not get more negative feedback*, i.e. to protect their already fragile ego (Rook, 1984). As evidence for this notion, look at the way lonely people

interact: they over-comply (to avoid criticism?), they become cynical, mistrusting, and rebellious (to discount any negative feedback?), or they simply don't interact or disclose (giving no grounds for a negative opinion?). This suggests that the underlying problem is frequently a low self-concept or shame (discussed in cause #13 above) within the inner child (Chopich & Paul, 1990, 1993).

Lonely adolescents unwittingly adopt harmful ways of escaping the sadness, including: getting excessively involved with an idol, often a recording artist, film star, or a sports hero. Another unproductive coping mechanism is to deny any interest in socializing more or in relating more intimately: "I'm not interested in having a girl/boyfriend." Other young people deny that they feel lonely: "I really didn't want to go out." This self-conning reduces their motivation to change. Finally, rather than developing social skills and meaningful relationships, a person can find other forms of gratification or escape, such as drinking, drugs, partying, TV, reading, and other "fun." Gaining awareness of these escape mechanisms might help the person get motivated to learn social skills and build his/her self-esteem.

When people are asked "What do you do when you get lonely?", about 50% say: read, listen to music, and/or call a friend. Altogether, their responses can be grouped into five categories: (1) sad passivity (cry, sleep, watch TV, drink, take drugs, eat, do nothing), (2) active solitude (work, read, write, listen to music, exercise, involved with hobby), (3) spend money, improve appearance, (4) reason with one's self: "I have had friends," "I have good qualities," "It won't last forever," "What can I do?" and (5) call or visit a friend, help someone, join support groups (Rubinstein & Shaver, 1982b; Rook & Peplau, 1982). The first category--sad passivity--is common for the lonely; they seem to be saying, "I'm sad and helpless; love me, take care of me." The other categories are pretty good self-help methods.

Peplau and her colleagues at UCLA (Peplau & Perlman, 1982) have observed how new students cope with loneliness. Several findings are of interest. First, the students who were still lonely after seven months had tried the same behavioral and mental techniques as the students who had overcome their loneliness. The main differences were these initial attitudes among the lonely: lower self-esteem, expecting less out of relationships, and blaming the lack of friends on their unchangeable personal traits. The same cognitive characteristics found by other researchers. Second, the people who overcame being lonesome had developed more friendships, not necessarily more dating relationships although dating helps. Third, overcoming loneliness wasn't so much how many friendships one had made, more important was the quality and depth of the friendships. So, skills at getting intimate may be more important than skills at meeting people.

Self-help methods for reducing loneliness:

There are several helpful books that generally deal with loneliness (Hojat & Crandall, 1989; Burns, 1985; Beck, 1989; Jampolsky, 1979). Mental health workers tend to recommend Shahan (1981). Also, see references at the end of this section and review the section on shyness in chapter 5.

Before looking for self-help methods, it is important to get rid of your attributions that block your attempting constructive changes. If you are blaming your loneliness on something somewhat unchangeable, say your height or lack of education or money or some permanent personality trait, stop using these excuses and focus on the things you can and are willing to change. If you are blaming the other person, say their lack of interest or time, or the situation, find things that you can do to meet people, such as working on your shyness, learning where and how to meet more people, learning to be a better conversationalist and how to help others with their troubles, etc. You have to get over this stumbling block of hopelessness before you can optimistically attack the loneliness. Now, look for methods that appeal to you.

Level I (behavior): get active in pleasurable social activities (Lewinsohn, et al., 1986), increase your competency at work, school, and in other activities--able people have more to give others. If you are aggressive and domineering, see chapter 7 and use several behavior-change methods in chapter 11. If you are passive, quiet, and unassertive, see chapter 8 and take assertiveness training (method #3 in chapter 13).

Level II (emotions): reduce shyness and fears of interacting (see chapters 5 and 12), reduce hopelessness and depression (this chapter and 12), handle resentment of previous lovers (chapter 7 and 12) and dependency (chapter 8 and 13). Lonely men are more critical of new acquaintances than non-lonely men (rejecting others first?); you can't judge a person in just a few hours; more tolerance would help you avoid prejudgment (chapter 7). Chapter 10 might help you find a new love.

Every social person must learn to accept rejection, not every relationship works out and lasts forever, not everyone will like you nor will you like everyone. Lonely people make two big mistakes in this process: (a) when socializing they feel they are being evaluated. Thus, they start to worry about the impression they are making. This makes them uptight instead of relaxing and being fun to be with. (b) Because they think they have been evaluated, when someone rejects them it becomes "proof" that they haven't measured up, that they have failed and are unattractive or no good. These wrong conclusions must be corrected. Most people are just wanting to have a good time; they aren't spending their evening assessing all your strengths and faults so they can calculate your total worth as a person. Correct this thinking, get lots of rejections, and use desensitization to reduce the emotional

trauma of rejection. Lighten up, stop expecting everyone to love you, stop being self-critical, take the initiative and bring up interesting topics, don't "play it safe" and hide in the crowd, focus on other people and their interests, help others have a good time, and be satisfied with your efforts. Practice, practice, practice social skills.

Level III (skills): See chapter 13 for several important skills: social and dating skills training for meeting people, assertiveness training for improving relationships, empathy and self-disclosure training for deepening relationships, decision-making and problem-solving training (self-help) for planning the future with others and alone. My experience has been that poor conversationalists benefit most from learning empathy responding. It provides a different-but-easy, highly effective, caring, genuine way of responding one to one. If you frequently don't know that to say, be sure to learn to empathize.

According to Richard Bootzin at Northwestern University, the people who handle being alone best have been encouraged by their parents to be independent, active, and self-sufficient. If being alone is difficult for you, desensitization should help and you will need practice enjoying being alone. Find some interesting and worthwhile activity, like get a part-time job interacting with people, read parts of this book, etc. It has been reported that once people learn to enjoy themselves alone, they can reach out to others more easily; they certainly look less needy.

Marital enrichment and therapy groups can help troubled relationships. Readings, social skills training groups, and self-help groups for the lonely, the separated, and the bereaved are important. Training groups have special advantages: modeling, practice (role playing), immediate feedback, and support or advice from the group for your efforts in real life.

Level IV (cognitive): Young (1979) developed a Cognitive Therapy approach to loneliness. There are many common irrational, problem-causing ideas or assumptions (and "automatic thoughts") associated with each stage from aloneness to togetherness: Do you think any of these thoughts?

Stage 1: Being alone

- Being alone is terrible. There's something wrong with me. It's better to be at home alone than go out alone.
- I'm ugly and boring. People only like beautiful people.

Stage 2: With casual friends

- I'll make a fool of myself. People will laugh at me.
- No one likes me. No one cares about someone like me.
- Better not trust anyone. People will take advantage of you.

Stage 3: In a situation for mutual self-disclosure

- I'm different; they wouldn't understand me. If I were honest, people would hate me. I'd better pretend to be different.

Stage 4: Meeting a potential boy/girl friend

- There's no one available. I always get hurt. There's only one perfect person for me. If you are attracted to them--if "the chemistry is right"--that is all that matters (no need to be any more selective than that).
- He/she won't like me. I can't approach guys/women. It would crush me to be turned down; I'd rather not approach anyone.

Stage 5: Getting intimate

- I always screw it up. I can't stand to be dumped again. If you're dumped, there's something wrong with you. If people really care, they have no right to leave.
- I can't relax during sex. I'm not a good lover. I'm fat. They will be judging every move I make. If the sex isn't good, it's my fault.

Stage 6: Making an emotional commitment

- I can't meet all his/her needs. I'll lose my real self if I fall in love. I should meet all his/her needs. It would be terrible if we didn't love each other equally.
- He/she will leave if I say what I really feel. I never get what I want. People should give me what I want without my having to ask them for it. If he/she criticizes me, he/she is about to leave.
- My partner won't change even if I ask him/her to. He/she is a different person now. Things should be done the right (my) way. If my partner won't change when I ask him/her to, he/she doesn't love me.

The first task is to identify the automatic, self-defeating thoughts you are having. Then question if these thoughts are really true and do some experimenting to see //it's more pleasurable (less hassle) to stay home than go out alone, //others always consider you dull and boring, //you can learn to tell interesting stories and jokes, //there is evidence that others are constantly evaluating you, //a friend can be trusted with your personal feelings, //it would be crushing to be rejected, //classrooms yield different partners than bars, //personal traits might be more important than looks, //there is a "middle ground" between saying nothing and complaining frequently, and on and on, until your thinking becomes more realistic and helpful and less depressing.



A friend is a person who, when you have made a fool of yourself, doesn't feel you have done a permanent job of it.



Several writers have suggested finding solace, instead of misery, in solitude (Andre, 1990; Storr, 1988). That's changing the situation by looking at it differently or reframing.

Level V (unconscious factors): Jules Henry (1971) observed, "People are lonely because they are vulnerable and they are vulnerable because they are alone; they are vulnerable when they are without love and they are vulnerable when they have it." Almost everything that threatens us makes us aware of our aloneness. Example: the more we need others for protection (and the more we distrust our protectors), the lonelier we feel. So if we are threatened by an economic depression, by a collapse of our government, by the failure of Social Security, by war, by unemployment, we feel alone--we fear abandonment. Splitting with others over political, economic, social and other issues increases our aloneness. This may seem abstract, but Henry points out that we are vulnerable to failure every day. The fear of failure confronts us in school, at work, in sports, in love, etc. When we face failure--like taking a test--we are alone and we feel needy. When we run away from stress, we usually run alone.

Most psychologists and sociologists see loneliness as a result of the environment (as in the last paragraph). Taking a different viewpoint, Ben Mijuskovic (1980), like the Existentialists, regards aloneness as the basic nature of humans, not a result of our childhood or our circumstances. He says loneliness is not an illness to be "cured" or treated with social reform; it is an unavoidable human condition to be faced. As we recognize our aloneness, we struggle desperately to find something more stable than ourselves to depend on. Death is not horrifying to us because it might be the end of everything, i.e. no awareness whatsoever, but rather because our consciousness might continue and we would be all alone. It is interesting, indeed, that all conceptions of an afterlife involve being with God and others or returning to life in another form, i.e. a way to reduce loneliness.

Thomas Wolfe in *Look Homeward, Angel* wrote about one of his characters: "He understood that men were forever strangers to one another, that no one ever comes to really know any one... Which of us has known his brother? Which of us has looked into his father's heart?... Which of us is not forever a stranger and alone? ...we escape it (aloneness) never, no matter what arms may clasp us, what mouth may kiss us, what heart may warm us. Never, never, never, never, never."

Mijuskovic says we try to keep ourselves occupied with studies, work, chores, social activities, what others are doing, TV, music,

reading, etc. to avoid recognizing our aloneness. We may try sometimes to be our unique selves, but that only highlights our aloneness and we are driven back into the warmth of our family and friends and social-moral causes, all of which falsely reassure us that we are not alone.

According to Mijuskovic, the lonely, frightened, needy human race, with remarkable facilities for creative imagination, created God. For humans, God is an invention to cope with fears and loneliness. God is a kindred but omnipotent being who is always there, always watching, listening, caring, and loving us. God is our reassurance that we are not alone, that we are not helpless, that we will not have lived in vain (uselessly), and that we will have everlasting life. We really feel alone in those fleeting moments when we doubt God. Yet, it is surely possible that the human mind created God, rather than God creating humans.

Do not miss Mijuskovic's point about aloneness: it is the nature of humans. A belief in a personal relationship with God may lessen that loneliness to some extent, regardless of whether God exists or not, but it can not "cure" or change human nature. Nevertheless, it is my opinion that religious involvement is an excellent approach to loneliness and sadness //it draws us emotionally closer to others, //it helps us feel loved and lovable rather than guilty, and //it actually increases our goodness rather than our self-serving interests (La Haye, 1976). Likewise, a government that encouraged and helped each of us to personally help others, in whatever ways we could, rather than just forcing us to pay taxes (a cold, impersonal, unappreciated act) to do good, would greatly reduce our alienation and lack of purpose.

The more aware, thinking, questioning, insightful, and autonomous we are, the more we decide our own values and responsibly run our own lives, the more we are true to our real and good selves, then we can relate to others better, like ourselves better, and overcome loneliness. But we will always be lonely because we need and want more from others than they can give.

One of the more specific and practical sources of help with loneliness is Brassell (1995). Several other books will help with loneliness and intimacy: Lerner (1988), Burns (1985), Rubin (1983), Bach & Deutsch (1970), Beck (1989), and Buscaglia (1984).

Loss of Status: Failure and Disappointment

The world is filled with obstacles and critics. When we try and fail, we feel sad. Failure is often a defeat--a loss of status in the eyes of others and/or a loss of a wish or self-respect. The more ego-involved we are, the more bitter the loss. Generally speaking, if you don't try, you can't be defeated or feel defeated--you haven't played the game. Also, any life challenge or test has to be reasonable before we feel like a failure, e.g. most of us could fail a test in advanced calculus today

and say, "So what?" It isn't reasonable to expect us to know calculus without the course.



Disappointment means falling short of achieving one's goals or wishes. This is clarified by William James's 1890 formula:

$$\text{Happiness} = \frac{\text{Accomplishments}}{\text{Expectations}}$$



If you get about what you expected, i.e. accomplishments equal expectations, you will be happy. But the formula also suggests that unhappiness may result in two ways: (1) failing to reach reasonable goals (accomplishments) or (2) setting unreasonable, impossible goals (expectations). The latter is a complex problem. Our society encourages aiming high--"try to be the best." Many people want to be better than average, certainly not be "below average." Yet, by the nature of mathematics, exactly half of us must be below average in intelligence, looks, and income as well as height. No wonder some of us "below average" people withdraw from the competitive "rat race." Sometimes it's wise to lower our expectations and avoid unreasonable demands, but when?

It isn't a simple matter of lowering our sights so we never fail and, consequently, become blissfully happy. First, some accomplishments (relative to your potential) are necessary for self-esteem (see chapter 14). Second, some people take satisfaction from having a dream--some inspiration--and striving for it day by day, even though they never reach their goal. Others have a lofty dream--being president, an astronaut, a professional athlete--but neglect the detailed, daily work of accomplishing that dream. Having the dream provides some payoffs. Dreamers run the risk of being disappointed and self-critical later.



Fred Astaire was told "he can only dance a little;" Beethoven--"hopeless as a composer;" Caruso--"he can't sing;" Disney--"has no ideas." Great talent may often go unrecognized.



Other people have argued that the focus of James' formula, happiness, is of secondary importance. Garcia (1971) contends that happiness should not be life's main goal. He claims accomplishments--seeking knowledge or helping others--are far more important goals and more realistically satisfying in the long run than happiness (see chapter 3). Fourth, the facts are that some unhappy people have given the world great accomplishments--Lincoln, Gandhi, Goethe, Luther, Van Gogh, Mark Twain, Beethoven, Michelangelo, and many others. If they had to choose between happiness and the accomplishments they gave us, which do you think they would choose?

How we handle failure is critical. An achiever acquires confidence and pride by taking on challenging life goals, by using good models and methods for getting there, and by putting in the time and effort to make the accomplishments meaningful. In contrast, a low achiever (see attribution theory in chapter 4), preoccupied with avoiding failure, will either choose an extremely easy task or a very difficult one. Neither task puts him/her to a test; both the very easy and the impossible are cop outs.

The achiever is "mastery-oriented;" the low achiever is "performance-oriented," i.e. he/she is most concerned with avoiding failure and looking good, not with learning or mastery. In contrast, the mastery-oriented person welcomes tough challenges because he/she is most concerned with learning something worthwhile, not building an image. After a failure, such a person would say, "Okay, I didn't win but what a learning experience! I'll practice another approach and then try again."

To the extent that more effort and learning better skills would significantly improve our performance, it is important to take control of the situation, rather than blaming our poor performance on factors that are not under our control. In short, to manage our life we have to take responsibility for it--take charge. It is the reason we give ourselves for the failure that determines how we feel:

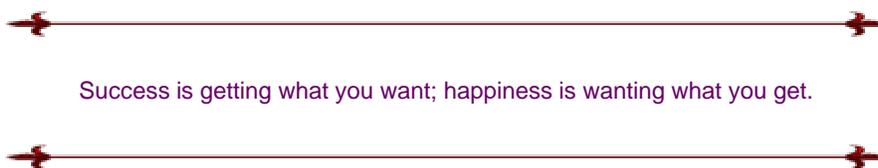
Explanation for Failure	Feeling	Solution
"I need more practice"	Confident, motivated	Gain skills, try again
"I can't do it"	Inadequacy, hopeless	Work harder, learn more skills, or accept situation
"I didn't work hard enough"	Self-critical	Try harder, use better methods & time management
"It was too hard for me"	Inadequacy, sad or mad	Develop better skills or strategies; lower goals
"It was _____'s fault"	Anger, unfairly treated	Assertiveness, demand justice; be responsible

"I had bad luck"	Disappointed, surprised	Look for other reasons & try again
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After a disappointing performance, it is important to ask yourself, "Honestly, now, what were the causes? What can I do about each of those causes?" A wise person will guard against assuming unchangeable factors are the sole causes of his/her problem and learn instead to concentrate on the factors (causes) he/she is able to change. Almost no complex behavior is totally caused by fixed factors, such as heredity, innate ability, physiological factors (height), etc. Most behaviors can be improved. Don't discount the importance of learning in any performance. Remember how many hours goes into making an outstanding star in any sport, often 4 to 6 or more hours a day for years, starting at 6 or 8 years of age or younger. If any of our current "stars" had an identical twin who had never played their sport, no doubt the twin, like you, would say, "Wow, I could never *skate or dive or shoot or hit* like that." Humans can learn a lot more than they think they can (I didn't say easily). Most failures don't prove a lack of ability, they reflect a lack of effort or learnable skill. In most areas we will never know our limits because we will never push ourselves to the limit.

It is obvious that some of the "reasons" above are excuses for our failures. Self-handicapping is a similar process, except it occurs *before* the performance rather than after. Common excuses arranged in advance for a poor performance are: I'm very tired, sick, drunk, anxious, unprepared and so on. In these situations, the person is using the old TA "Wooden Leg" game, "how can you expect me to run fast when I have this wooden leg?" Self-handicapping excuses do reduce some immediate anxiety and disappointment after failure, but in the long run they usually lower our self-esteem and increase our fears. Why? Because we haven't performed very well in the past and because a part of us knows we are deceiving ourselves and others. Pride is primarily felt when we truly "do our best." See the discussion of underachievement in chapter 4 and self-handicapping in chapter 5.

In summary, sometimes we are too hard on ourselves, expecting too much, and sometimes too easy, not expecting or trying to do our best. You may be too uptight about achieving your dreams; you might not be uptight enough to achieve them. Ideally, I suppose, one would be inspired by his/her ambitions and visions of the future, but down-to-earth enough to accept (for the moment) whatever he/she actually accomplishes. All of us need to ask, "How can I do better?" It reminds you that you are in control and don't have to do poorly. Review the sections on self-efficacy and optimism in chapter 14.



Low Self-Concept and Feelings of Inferiority

Alfred Adler, a student of Freud's between 1900 and 1910, had been a sick (rickets and pneumonia) and weak child. He had seen a younger brother die and been close to death himself several times. He overcame his fears, became a model youth, and went to medical school. His early medical practice was in a poor area that included a circus. He found that many of his patients were strong and skilled circus performers who had overcome and over-compensated for some physical weakness. It is understandable that Adler gave the concept of "inferiority complex" to the world (Monte, 1980).

Children see their parents as powerful and able. In comparison, they feel weak and inferior. Life becomes a struggle to make up for our frailties and to put up a front of strength and superiority which will hide our feelings of inadequacy. Adler came to believe that all people yearn for mastery and perfection. We all struggle to find our place and adapt better and better to the world. He saw this striving to overcome inferiority as humans' basic drive; he saw humans as basically good, in contrast to Freud.

As mentioned in the theories sections of the last chapter and this one, certain parenting practices may cause excessive feelings of inferiority: over-critical, over-demanding, over-protective, over-controlling and probably others. Anyone with a negative self-concept based on these childhood experiences needs to start afresh honestly re-evaluating themselves. Professional help should be considered.

Traumatized Without External Trauma

An impressive series of studies on mastery-oriented thinking has been done by Carol Dweck (2000). Her focus has been on achievement but her findings are relevant to depression and coping with crises. She emphasized that a crucially important distinction in any situation exists between hopeless thinking and mastery thinking-- between believing that when I fail or things go wrong that means I lack the ability ("I'm not smart enough") and believing when I fail, "Hey, I have more to learn" or "I have to get smarter, do it a different way or try harder." This latter healthy optimistic attitude leads to intrigue with exploring the world, taking on difficult tasks, and achieving well... coping.

Dweck's findings lead her to explore the early childhood sources of hopeless thinking or mastery thinking. She found that over one-third of children show signs of helplessness--self-blame, frustration, sadness, giving up, losing interest--when they fail or are criticized, when things go wrong. In the preschool years, children are not concerned yet about being intelligent or dumb, they are concerned with being good or bad. (Slightly older children become concerned with being smart or dumb.) Therefore, when kindergartners who showed

the signs of helplessness failed, they felt they were bad. And they thought badness was a stable trait--"that's the way I am." However, when kindergartners with a mastery-orientation failed, they simply assumed they were still good but needed to do something differently--they thought their intelligence or coping ability was changeable! Through several experiments, it was shown that judgmental criticism of the child increased his/her helpless attitude and negative self-appraisal, including deeply feeling unworthy or bad. Neglect and criticism are the classic sources of a low self-concept. However, critical feedback that included suggesting trying a new approach or exerting more effort produced a mastery-oriented reaction, not self-criticism.

Now, what about praise? If negative judgmental criticism harms, does praise build confidence and mastery? Well, usually but sometimes not. Why not? Because statements like "Oh, you do that really well--that's good" or "You learned that quickly--you must be really smart" imply to the child that his/her basic qualities can be inferred from their performance. Therefore, when a child who has learned to think this way fails, one obvious possible conclusion he/she might draw is "I'm no good" or "I'm stupid," even though the person giving the feedback had not said anything like that. I consider this an important finding. Praise worded somewhat differently, e.g. that says "you did really well, you must have tried very hard," did not result in helpless thinking or in "I'm dumb--that's the way it is" preoccupation when they later experienced a failure. Praise that attributed success to effort or a good strategy led to optimistic mastery-thinking.

We clinical psychologists are prone to assume that a child with a self-degrading, self-hating, defeatist attitude lived in a neglectful or psychologically destructive early environment. Often that is true. But this research provides evidence that negative self-concepts can come from simple mis-interpretations of genuine compliments by a 5-year-old. It seems incredible that such mis-interpretations ("failure means I am bad") repeated perhaps thousands of times might lead to a suicidal teenager or a self-injuring 25-year-old. But, in some cases, our minds may actually develop in what, at the time, seem to be accidental or capricious--unpredictable--ways. Yet, one can understand how negative, self-destructive thinking can arise from a child's misunderstanding and without any abuse.

At this stage of our knowledge, Dweck and Sorich (1999) wisely caution against labeling children "very intelligent" or "really gifted." Further supporting this caution, they found that children praised for their intelligence became so invested in looking smart that 40% lied about their scores to "look good." And, at the same time, the intelligence-praised kids started selecting tasks that made them look smart and avoiding tasks that afforded more challenge and more learning opportunities (which effort-praised children selected). Self-confidence seems to rest on the belief that "I can do better by trying harder" which is built on praise and appreciation of effort and problem-solving strategy. Thus, mastery-thinkers focus on how to accomplish some goal, how to use their skills, increase their abilities, sustain their

efforts in spite of setbacks. I-want-to-look-smart thinkers focus mainly on polishing their image. Hopeless-thinkers re-live how awful the failure/crisis has been without carefully considering possible solutions. In summary, through no fault of their own, some people in childhood learn to emphasize the awfulness of the problem and/or their own badness, while others optimistically increase their efforts to solve a problem when things go wrong and/or put it behind them. If the self-defeating attitudes are learned, they surely be unlearned.

Freud spoke of the "success neuroses" consisting of four motives: a need to achieve, a fear of success, a fear of failure, and a desire to fail. The fear of failure can cause us to be nervous (and not do well) or to give up; it can also cause us to work very hard, just like the need to achieve. You may doubt that there is a fear of success and a desire to fail. Some women report feeling reluctant to beat males at tennis or to appear too smart. Supposedly men's egos are fragile; they are thought to dislike losing to women. Tresemer (1974) found about 50% of both men and women exhibited negative feelings toward achievement--or assumed other people had such feelings. As you can see, the fear of success and the desire to fail get all confused with (a) opposition to the traditional pressure to succeed and (b) reluctance to accept additional responsibilities following success.

Clinicians frequently see people who have an acceptable record in school or on the job and are ready to graduate or be promoted but then they mess it up or drop out. Carl Menninger (1956) wrote a book, *Man Against Himself*, about such self-defeating behavior. Cudney (1981) suggests that self-defeating behavior is caused by our reluctance to face reality. By failing (while pretending to be trying to succeed) we deny our responsibility for what is happening. That way our goof-ups can continue but "they aren't my fault."

If you are working on a task you really don't want to do (e.g. a college major that was pushed on you by a parent), it seems plausible that your resentment might result in your failing. Failure can serve other purposes: keep you dependent, get sympathy, frustrate or disappoint others, and confirm your belief that you aren't any good at _____.

Because we try to hide our self-doubts, it is not easy to tell what others feel or even what we feel. Indeed, feelings of adequacy and inadequacy may co-exist or change frequently. Gilmer (1975) lists six signs of inferiority: (1) over-reaction to criticism, (2) tendency to feel criticized, (3) avoidance of others, (4) an excessively positive response to flattery, (5) inability to lose graciously, and (6) urges to put down others. Perhaps these will help you identify your feeling more clearly.

A hallmark of depression is pessimism and self-criticism. If you expect to fail, that increases the chances you will fail or not even try. But the depressed person's self-appraisals are frequently too low. They were found in one study of problem-solving ability (dealing with interpersonal, intrapersonal, and emotional problems) to be *more*

capable than they think they are and just as capable as nondepressed people (Blankstein, Flett, & Johnston, 1992). So, honestly testing their abilities may remove unhealthy doubts.

Feeling good about yourself, i.e. having self-esteem, one might guess would be associated with being happy. That's true but it may not be that simple. Moreover, measures of self-esteem and happiness tend to be rather stable over a life time, suggesting self-concept changes are often hard and take time. We don't understand that thoroughly. To change self-esteem one may need truly major life changes—long lasting success or failure—and/or demanding self-help efforts (see chapter 14). Research suggests that feelings about yourself are more easily changed in childhood or in late-middle and old age. Adolescents, young adults, and middle aged people may find it harder to change their self-concept. However, children and young teens who experience a serious traumatic emotional distress may blame themselves for failures, fear more failures, and doubt themselves socially (but not necessarily academically). Some theories suggest that people who are chronic self-doubters tend to be more materialistic, supposedly to prove their self-worth.

It is commonly believed by professionals and lay persons that low self-esteem causes many problems, such as difficulty with school work, marital problems, abusive parenting, crime, and alcohol or drug abuse. For instance, Sandra Murray at the University of Buffalo has published articles showing that marriage partners with low self-esteem sabotage their marriage by thinking their partners love them less than they really do. The insecure partner expects to be neglected or criticized but before a slight or imagined rejection actually happens they attack the partner who, in turn, strikes back later with "you are so irritable, so insecure, so needy."

There is certainly some evidence (and logic) that high self-esteem contributes to happiness and low self-esteem is related to suicide attempts, eating disorders, teen pregnancy, and other problems. However, all these connections (and other similar conjectures) have not been proven to always be true. Indeed, there are also people who believe that thinking too highly of one's self leads to problems, such as angry responses when criticized, lack of motivation, violence, and racial-ethnic attitudes. And, in a positive direction, doubting one's abilities may have resulted in many people working very hard and doing well in school or on a job. As usual, internal dynamics are complex.

Other psychologists contend that some people are racists or violent or tax evaders because they don't feel bad or guilty *enough* to stop such behavior, not because they feel deep down very negative about themselves and project that self-hatred on to others. Thus, a therapist might attempt to focus on self-control instead of self-esteem, including increasing the patient's awareness of his/her hurtful behavior in the past rather than thinking "I'm OK" or "I'm a good person." Awareness of our negative traits might also be beneficial, e.g. recognizing one's

excessive need for social status or for an ego boost through material possessions, dominance, good looks, clothes, good grades, approval of friends or family, etc. These insights could help us avoid being unnecessarily self-centered.

Some writers (Nanka, 2002) describe a related attitude—I-am-always-right or Everyone-should-agree-with-me. Perhaps these arrogant behaviors or feelings spring from underlying fears of being wrong, feelings of inferiority, from a desire to be superior or from some other dynamic. Regardless of the source, these dominant personalities get irritated and critical when others disagree with them. They may become self-righteous. People wanting to be right and in control seek a closed system which will keep out the different ideas of other people. Others in such a system, however, are likely to feel controlled, frustrated and angry. When this occurs in a family or in a work group, people become unhappy. Note: an interesting research finding reports that authoritarian men *with high testosterone* avoid intimacy, are more aggressive, less happy, and have a divorce rate twice as high as men with less testosterone. Interesting...but read on.

Other researchers (Taylor, Lerner, Sherman, Sage & McDowell, 2003) found that when self-enhancement (crowing about your good traits) is done modestly and tactfully, it is generally accepted. It even results in good scores on measures of mental health and in good relations with others. So, quietly blowing your own horn and wanting to be right (and believing you are) seem to have very different impact on others. Science hasn't clarified these subtle aspects of social life yet, but they will...and in the mean time, I'll bet a skillful observer—or an honest friend--could tell you whether your self-enhancing comments are seen as positively or negatively by most others.

What other self-help techniques could be used against feelings of inferiority?

Level I (behavior): Do a behavioral analysis (method #9 in chapter 11) to find out what initiates and reinforces the negative thoughts or self-defeating behaviors or self-put-down comments. For example, do you get attention? Do people rescue you? Do you avoid difficult tasks? Do you upset anyone? Develop more positive, adequate behaviors.

Level II (emotions): Since feelings of inadequacy become associated with specific situations, just as fears do, we can break those associations with desensitization. That is, we can become more tolerant of our weaknesses (this may be our only choice if an actual inadequacy can't be overcome, such as a speech defect). Or we could simply face our weakness, if it is remedial, and compensate--make up for--or over-compensate for it by becoming highly competent in our weak areas or some other area. This may not require any special skills, just lots of practice.

Level III (skills): The most straight-forward way of overcoming feelings of inadequacy is to *be adequate!* For most of us, that means acquiring new skills, especially if we want to become *highly* competent. Example: if making conversations is hard for you, there are many skills that would be helpful, e.g. reading and learning various viewpoints about interesting topics of conversation, practicing in fantasy different ways of expressing those views, learning more about being persuasive, etc. In some cases, it may be more practical to become highly competent in another area, not your weakness. For instance, the poor conversationalist could become an excellent writer and build his/her self-esteem in that way. Many ego-building skills are available in chapter 13.

Level IV (mental): Self-efficacy and confidence in changing behavior or fears were discussed in chapters 4 and 5. In this chapter, we refer repeatedly to feelings of helplessness which could be counteracted with faith in self-help (or an external source of help). And, we have seen how Rational-Emotive and Cognitive therapies address the self-pity involved in "awfulizing" when things go wrong and you feel low. Building self-efficacy and a positive self-concept are dealt with by methods #1 & #9 in chapter 14.

There are several good popular books for increasing self acceptance; read some (Dyer, 1976; Ellis & Harper, 1975; Greenburg & Jacobs, 1976; Jampolsky, 1979, 1985; Newman & Berkowitz, 1974). Be sure to review methods #1, #3, and #4 in chapter 14. Many people are saddened by their physical appearance, always wanting to look better; Cash (1995) offers practical advice specifically for the 35% of us who don't like our bodies.

Level V (unconscious): Like Sooty Sarah, it might help to understand the source of one's low self-appraisal, not so one can hate the source but so one can see that self-criticism is *your* choice and is not needed. Driscoll (1982) gives several reasons for self-criticism: (1) to motivate ourselves to do better, (2) to keep ourselves humble, (3) to avoid doing something challenging, (4) to avoid disappointments, i.e. when you fear failure, (5) to discourage others from criticizing us, (6) to encourage others to admit their faults too, (7) to avoid responsibility--"don't expect much from me," (8) to imply we have superior standards by saying our behavior was beneath us, not reflective of our true abilities, (9) to get sympathy and reassurance, (10) to express other feelings indirectly, such as anger or guilt or a need to be in a subordinate position within the family. It takes a keen, careful observer to detect these motives.

If there are reasons to believe you are too self-critical, avoiding success, or seeking failure, surely understanding your underlying needs and false assumptions (usually the need to hurt yourself or others) would be helpful. Talk to a friend or a counselor about what might be "going on inside you." See references above, especially under level IV.

Perfectionists and Worriers

The perfectionist often sets very high standards for him/herself...and sometimes for others. Certainly, lofty standards are a good thing but they can become a barrier rather than an aid to completing a task.



A man would do nothing, if he waited until he could do it so well that no one would find fault with what he has done.

Cardinal Newman, 1801-1890, British Preacher



It is helpful to think of good or normal perfectionism and problematic or neurotic perfectionism. *Normal perfectionism* involves the desire to excel and take pleasure from putting in extraordinary efforts without feeling compelled to be perfect. It is setting high personal standards while accepting one's personal limitations, so one feels good about a job well done. *Neurotic perfectionism* involves excessively demanding standards that often cause the actor to feel stressed, unhappy and personally critical. Sometimes perfectionists are actually less effective because they fret about mistakes, worry about slow progress, and try too hard to impress others. Some are upset by negative self-evaluations; it is almost: "if I'm not perfect, I am bad." At least, they have a strong need to avoid mistakes. Sometimes, however, they harshly focus on their errors and stupidity instead of figuring out how to correct or avoid their mistakes. In a few cases, neurotic perfectionism can contribute strongly to despair, fear and depression.

The worrier and the perfectionist probably learned this kind of thinking as a child from a parent. Perhaps they adopt their parents' inappropriate standards or internalize their negative judgments. The perfectionistic parent feels badly if his/her child fails, then pressures the child to make no mistakes or to be a "little angel." The child learns that making mistakes leads to the loss of love but doing something perfect means "I'm OK." Since the child's self-evaluation is based on what others think of him/her, it becomes important to be perfect all the time. As the child gets older, the standards are set higher and higher, increasing the chance of failing.

A child may seek approval by being compulsive or orderly or overly concerned with cleanliness. Of course, these behaviors may be in your genes too. Hewitt and Flett (2002) describe three kinds of perfectionism: (1) Individually maladaptive—when a person is obsessed with possibly failing to reach impractical self-assigned goals,

resulting in anxiety and/or depression. (2) Socially induced—where the person's culture or general social environment demands very high performance, resulting in feeling unable to make the grade. (3) Imposed by specific others—usually a parent, a boss or a spouse who insists on perfection, resulting in a miserable situation. In short, there are several ways to get there.

Are you perfectionistic? Consider these questions: Do you try to do the best you possibly can in almost everything you do? Do you avoid doing things you can't do well? Do you get upset and harshly criticize yourself when you make a mistake? Is being average embarrassing to you? Do you expect to be outstanding if you work hard enough? Are you sacrificing your personal life for your career? Do you think people will think less of you if you don't do well? Do you value being precise and logical, and distrust your intuition and emotions? Do you over-emphasize the importance of what you say or do, or of your work? Do you often feel that one little flaw ruins the whole thing? Do people call you nit-picky or a control freak? Do you expect to be a super parent or to please everyone? Do you often feel guilty? Do you expect a lot of others too? If you are answering "yes," you are probably a perfectionist, maybe overly controlled and a workaholic too. Mallinger & DeWyze (1993) is a good reference for a compulsive perfectionist.

In general (there are exceptions), worriers with impossibly high standards are not better decision makers and more productive than people with more reasonable standards. Perfectionists are often over-demanding on themselves and have lower rather than higher self-esteem, poorer rather than better relationships (they expect perfect partners too), and less stick-to-it-iveness rather than more, according to David Burns (1980). Perfectionists strive for the impossible; they say to themselves "I must...should...ought to," rather than "I want...wish...would like." They are often slavishly avoiding failure, rather than eagerly pursuing excellence. They think in the same illogical ways depressives do (see theories above), e.g. they set unreachable goals, and then judge themselves to be failures. In addition, constant worry causes health problems. Tell yourself that it is unnecessary to be perfect; being average in many or most ways is just fine. You can change the way you think; you can avoid too high demands in the future and discard excessive regrets about the past (Freeman & DeWolf, 1989). But it may not be easy; perfectionists often fail to improve much in therapy.

There are seven steps in the treatment for perfectionism proposed by Burns: (1) list advantages and disadvantages of striving to be perfect, which should encourage the person to give it up, (2) rate the expected and then the actual satisfaction with several activities, which will show the person that he/she doesn't have to be perfect to enjoy an activity, (3) try for an entire day to rate many things as either perfect or not perfect, proving to the rater that the world isn't black (imperfect) or white (perfect) although he/she may think that way, (4) record for a day each self-critical thought and consider what would be a more reasonable and self-tolerant viewpoint, (5) design an

experiment to test the idea that people won't respect you if you are not successful (actually many will like you better when you mess up occasionally and admit it), (6) learn to handle criticism by role playing that situation (see chapter 13), and (7) experiment with different standards, i.e. try for an "average" meal, a "below average" essay answer, a "poor" appearance one day and "a little above average" the next, etc. Bring a little variety into your life, not just perfect, perfect, perfect... Loosen up, it's usually more relaxed and fun that way.

Another self-help book (Elliott & Meltsner, 1990) also shows how to tell the subtle but important differences between seeking excellence and demanding perfection of yourself. Striving to do your best is very different from insisting on being perfect and better than everyone else. One is free; the other is a slave to an impossible standard. One welcomes challenges, the other dreads the task because he/she may not be perfect this time and someone else might do better. One faces the reality that people and things are not perfect, the other lives a lie, believing everything has to be done well. Elliott and Meltsner identify four types of perfectionists and, like Burns, suggest ways to stop driving yourself crazy. People who can't tolerate uncertainty--and who insist that the world be the way they want it to be--are likely to be worriers.

There are, of course, payoffs for being a worrier (worrying is also discussed in chapter 5, both under worries and obsessions). Examples of payoffs: in many instances, moderate worry will motivate us to work harder and create better solutions but excessive worry interferes with careful thinking and usually wastes time. Yet, we often have the illusory belief that worrying a lot will help prevent something bad from happening. Besides, if the outcome is bad, we feel less guilty and disappointed if we have worried and fretted over the matter. Also, if we worry a lot, people will think we are trying hard, e.g. a worried parent thinks this proves he/she is a good parent and assumes others will see him/her the same way. Worriers make mountains out of mole hills; that may get them attention. Moreover, if you worry and exaggerate the awfulness of some possible event, if and when it actually happens, you experience the event as less scary than if it were unanticipated.

It may also seem safe to become like your own parent who was a worrier. We may falsely attribute good fortune to worrying; thus, a person who worries about being assaulted, and never is, may think the worrying has paid off. Worrying about the outcome of a project may actually interfere with its completion; an unfinished project avoids failure (it can't be perfect). Worry often diverts attention away from the real concern: a young person worrying about being assaulted in the big city may actually be more concerned about leaving home and his/her parents. Likewise, the mother worried about her children may really be more concerned about her marriage. Certainly, no one enjoys feeling a little mistaken, not quite a "10" in looks, a little irresponsible or criticized by their parents, but perfectionism, self-criticism, and worry seem to yield unhealthy payoffs. By honestly understanding the

reasons why we have useless, unpleasant worries, perhaps we can learn to stop the excessive internal critic.

Worrying is often a spiral starting with a “what if” thought, such as “what if” something terrible happens—then “what if” something else awful follows that, and so on through a series of “what ifs.” The body tightens up. The mind fills up with more and more thoughts about mounting problems and looming catastrophes. You feel overwhelmed by the fantasies. The solution, according to Deanne Rapich (see <http://www.ConquerAnxiety.com/?mSG1a1>), is to

(1) Recognize you are being inundated by your own negative imaginings. So, get a good grasp of those thoughts by writing brief descriptions of your “what if” thoughts and fantasies so you can clearly identify the dreaded thoughts and fears as soon as they occur. Many of these ideas will be old habits of thought and foolish improbable notions that have shaken you up and put you down for years. Go through the worrisome “what if” thoughts you recorded and try to figure out your basic fears or core beliefs. Often you are afraid that people will get mad at you or judge you badly. Sometimes, we fear making stupid mistakes or doing something that would shock or offend others.

(2) The second step is to develop a more reasonable, more accurate, more positive expectation of what will happen. Ask yourself if the feared “what if” event occurred, what would really happen after that? Question your extreme predictions, for example, that others might not like something you do but *everybody* will not hate you...and those who get upset will not stay bent out of shape forever. Ask yourself what are the chances you could avoid making the mistakes you worry about and/or learn some new skills or a different approach? Now you can replace the exaggerated awful idea about what will happen with a more accurate, less worrisome expectation. At this point, you are prepared to quickly attack the “what if” thought the next time it occurs.

(3) The third step is, of course, to reinforce the new positive beliefs by repeating the ideas over and over. You can build new habits of thought. Almost certainly millions of people have learned, entirely on their own, to avoid depressing worries, to put them out of mind. See the worry section in Chapter 5 (<http://mentalhelp.net/psychelp/chap5/chap5q.htm#a>). You can, of course, be a worrier without being perfectionistic.



A tourist approached three men working with huge blocks of stone and asked, "What are you doing?" One said, "Bustin' my butt cutting hard stone." "Earning only five dollars a day," frowned another. "Building a great cathedral!" said the third with a smile.

-Unknown source



By understanding the development in several ways of our unhelpful perfectionism, perhaps we can come to grips with it (Adderholdt-Elliott, 1988). It is probably an old well worn habit. Maybe your parents were strict and punitive? Maybe you felt you needed to do real well to make up for weaknesses? Maybe being perfect was a way of avoiding punishment or getting attention and praise as a child? Maybe you became very anxious and self-critical when you didn't do well socially or in school, sports, games, or chores? Maybe trying real hard helped you feel better...or did it make you feel worse? As the reasons for your becoming perfectionistic become clearer, you may realize that you no longer need to keep making neurotic perfectionistic demands on yourself. Get on with living. Uncertainty is a part of life. You can't control everything but you can handle whatever happens.

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Guilt and Regret

Healthy, useful guilt is the feeling we have when we do something we rationally judge to be morally wrong or unfair. Just having the thought or urge to do something bad can cause guilt. That's good if it keeps us from doing something inconsiderate. Healthy guilt is our reasonable, fair conscience. But there is *unhealthy* guilt too. That is when we establish unreasonable standards for ourselves, i.e. we expect perfection, we want to accomplish the impossible, we feel responsible for misfortunes in other people's lives, we believe we are "good" only if we faithfully follow all the rules and do more than our duty. The unhealthy guilt does not allow for mistakes; we expect too much from ourselves and others.

There are two uses of the word shame. Some writers use it to denote the pressure we feel from others to act a certain way, i.e. a certain discomfort if we do not have the approval of others. Shame, in this sense, is the feeling of remorse and embarrassment when we believe our actions have brought discredit to ourselves or to others. Of course, peer and family pressure is a powerful motivator, but we can avoid this shame just by concealing our unapproved actions, thoughts, or feelings from others. The more recent use of the word shame has to do with self-disapproval, i.e. considering one's self as being inexcusably inadequate or defective. This is independent of other people's opinions of us and, thus, there is no way (without treatment or self-help) to avoid this destructive negative self-evaluation. Guilt is regretting our *actions* because we now consider our behavior to be unfair, immoral, or selfish; shame is a negative evaluation of part or all of our self as a person. I try to use shame only in this last sense. Shame is discussed in the next section.

Both guilt and social pressure are vitally important: they are of help in controlling "the beast within"--our greed, anger, and lust. They also help us fulfill our responsibilities--our work, studies, care and concern for others, taxes, show of love, etc. Our guilty conscience is vital in helping us be good.

On the negative side, excessive guilt (and shame) can create terrible suffering, even make life not worth living. Almost 80% of adults attempting suicide had histories of guilt (and/or shame). Among 3 to 14-year-old children who had tried to kill themselves, 25% were seeking to be punished for masturbating or wishing someone were dead (David, 1977). A guilty conscience can change our social lives, dampen our enjoyment of life, cause fears and worries, and create a heavy load to carry emotionally.

Some writers have made a meaningful distinction between "real" guilt and "neurotic" guilt. Real guilt is feeling badly about something you did that was truly morally wrong. Neurotic guilt is when you haven't done anything wrong or what you did doesn't warrant the amount of guilt felt. Real guilt may be expressed through neurotic guilt, however. An example will help. Suppose a depressed 18-year-old becomes obsessed about having stole another girl's underclothes when she was 14. That's neurotic guilt. It seems likely that the real guilt involves something else, not just old underwear. A psychoanalyst would suspect primitive infantile urges were causing the real guilt--e.g. closeness to one parent and resentment of another parent or a sibling. Other therapists would look for the source of guilt in more recently repressed guilt-producing acts or thoughts--e.g. anger at a parent or sexual temptations. Neurotic guilt frequently substitutes for real guilt (it helps hide what we are really guilty about).

Guilt or feeling immoral can result from having "bad" thoughts and wishes (even unconscious ones according to some therapists), not just overt acts. This is a great moral argument. Some people think thoughts and feelings, no matter how inconsiderate or destructive (like killing someone), are not immoral because they hurt no one. Yet, some great religions and thinkers have taught that "the thought is equivalent to the deed." Jesus said, "whosoever looketh on a woman to lust after her hath committed adultery with her already in his heart" (Matthew 5:27-28). Hinduism teaches that one is judged by his/her motives and desires, not just actions. Buddhism says, "All that we are is the result of what we have thought." Similarly, Freud's basic notion was that urges and fantasy, not just actions, shaped our character and determined our fate (Fingarette, 1971). Even recently, the pervasive cognitive movement in current psychology contends that thoughts influence emotions and actions. So perhaps we can't say "thoughts don't matter." But surely immoral thoughts, never acted on, should not generate intense guilt like an immoral act itself. Thinking of hitting you is not the same as hitting you. You will have to decide for yourself if immoral thoughts are okay (if still resisted), inconsequential, or bad (see catharsis in chapter 7).

It would be nice, perhaps, but impossible to be "pure" of heart (emotions) and mind. However, to the extent you use your thoughts and values to resist or diminish your immoral-inconsiderate emotional urges (as defined by you and/or society), you could be considered good and moral. Indeed, there is evidence that a stern conscience which carefully monitors our thoughts and urges is more likely than a weak one to stop us from being immoral (David, 1977). So, maybe evil thoughts and feelings aren't morally bad unless they start to overpower (or slip around) our conscience. Thus, the weaker our immoral impulses and the stronger our healthy guilt (or moral character), the safer we are from "sin" or unhealthy guilt.

Guilt may also come from comparing your living conditions to others and from not living up to our own standards. Many adults feel some guilt for living better than their parents. Some people feel unworthy of their successes. Some men and women in their forties, fifties, and sixties are now experiencing guilt about not serving in the military service in Korea and Vietnam. How can over 50% of us Americans go to fantastic colleges, while millions of children around the world get little or no education at all (*one billion* people are illiterate), without feeling some guilt underneath the denial and rationalizations? It's healthy and reasonable to have some guilt.

Where did your conscience come from? According to Erikson, in the first year of life you learned to trust or *distrust* people depending on how well your needs were met. If trust developed with someone in your first year, then during your terrible two's, when you were learning to eat with a spoon, to walk, to talk, to use the bathroom, and so on, you were able to develop an emotional relationship with someone. If from the caretaker you learned that you were capable, that you have limits but you're okay as a person, that you could test the limits, explore, get mad, etc. and still be loved, you acquired *healthy shame*. On the other hand, if during your 2's and 3's the caretaker was critical, impatient, mean, or humiliating, you would probably doubt your ability and feel defective or *shame* as a person. The "I'm defective" self-concept learned at such an early age makes it especially hard to handle the subsequent stages of development (see stages of development in chapter 9).

From ages 3 to 5 you were learning to do lots of things: communicate, eat without making a mess, ride a tricycle, throw a ball, ask lots of questions, etc. If you already had experienced love, developed trust and self-acceptance, and were continuing to receive encouragement and praise, your self-confidence and self-concept developed further. But, if you were further ridiculed and told "you can't do anything right," you learned to feel self-critical, guilty, and insecure. Remember, according to Freud and Erikson, at ages 5 or 6 you normally would start to identify more with your same-sexed parent, automatically and unthinkingly incorporating his/her values and moral thinking in the process (see chapter 5).

As your world expands, relatives, siblings, religion, teachers, friends, TV, and books start to influence your morals. If you aren't an unusually "thoughtful" or "questioning" child, much of your guilt may be a result of hand-me-down values, not moral principles you have carefully studied and chosen (see chapter 3). You can hardly be in charge of your own life unless *you*, as a thinking adolescent and adult, have decided your own goals, purposes, and values.

Although some of the passed-on morals, like honesty and fairness, have stood the test of time and the challenge of intelligent questioning, certainly some of our guilt comes from fallible people or social tradition and religious beliefs which may need to be reviewed occasionally to see if the values are still valid in today's world. For example, in my classes sometimes I ask the students to anonymously write a secret--something they would be afraid to tell us openly--on a piece of paper, knowing it will be read in class. Then the class responds to each "secret," usually with a lot of acceptance, understanding, and empathy. About half of the secrets are about sex: "I've had sex with someone I didn't love," "I've had sex with someone of the same sex," "I masturbate," "I'm attracted to well developed women/men," "I'm not a virgin" and so on. None of these acts are inherently harmful to others but our society has a lot of sexual taboos that produce guilt.

I remember a young and attractive but distressed coed who sought counseling after a date with her new boyfriend who pushed for sex. Neither had a means of birth control so she masturbated him. That seemed a lot wiser to me than having intercourse, but her priest was harshly critical at confession because masturbation is an "unnatural act." Her guilt resulted from the same religious condemnation of sex that had resulted in religious rules in the sixteenth century against married couples having intercourse on more than half of the days of the year (see Taylor, 1954, or Tannahill, 1982, to understand why the church fathers have been so concerned with sex).

Some of our guilt is almost totally irrational. For example, some married couples feel guilty about any sexual caressing that occurs outside the bedroom even though no one can see them. Many young children of divorcing parents feel it is their fault when the children were in fact a binding force, not the cause for friction between the parents. Maybe the child had wished one parent were not around. But, more likely, the child simply misunderstood his/her role in the conflict between his/her parents. Other examples of unreasonable guilt are when a young adult decides to handle sex differently than his/her friends (see the woman who was ashamed of her virginity in chapter 10) or decides to support a different political party or religion than his/her parents follow. Many of our sources of guilt need to be reconsidered. Remember, some of this guilt comes from the 5-year-old inside us with hand-me-down ideas.

What to do about Destructive Guilt

We have all done inconsiderate things or neglected to do considerate things. So, some guilt is justified; we wouldn't want to lose it. It's wonderful when we have the decency to feel appropriately guilty! We need a lot more of that guilt, in my opinion. But, the question here is: What can a person do about excessive, destructive, or unneeded guilt? What about regrets?

As indicated above, begin by exploring the reasons for your guilt. What have you done or failed to do? Should you feel guilty? What moral principles have you violated? Are these moral principles valid and reasonable (or worn out hand-me-downs)? Was it just an urge or wish or did you act? Were the circumstances partly to blame? Ask yourself if just because you did something bad, does that make you a bad person?

Are you making unreasonable demands on yourself? For instance, do you expect yourself to never get mad and impatient with parents, children, lovers, friends, and others? Do you expect yourself to like your body and be sexually excited by your lover's body but, at the same time, find nothing at all appealing about any other human body in the world? Do you live according to your values and life-style or according to current fashion or someone else's wishes? Are you a perfectionist? If you have done something immoral but there is no way to make up for it (be honest, don't cop out), do you keep on worrying about it (more than needed to keep you from doing it again)? Think about these issues. If useful, discuss them with others--parents, friends, ministers, counselors.

In this process, you are really checking the validity of your attributions (your explanations of your behavior). This is an area in which self-serving distortions abound, so review the ways we humans are frequently irrational (methods #3, #4, & #8 in chapter 14) and check out your own rationalizations for being inconsiderate of others in chapter 7. Consider this: Depression often involves feeling helpless, i.e. I'm-responsible-but-I-have-no-control over my life. Examples: "I'm a disorganized, rattle-brained person and I can't keep a job" or "Women see me as a nerd; the truth is I am dull and I can't change that." In contrast, truly feeling *guilt would seem to require "I'm-responsible" and "I'm-in-control" attributions*. Examples: "I had the time and I should have studied but I didn't" or "Oh, God! Why didn't I use a condom, it would have been okay." Guilt can be reduced if the attributions are changed to "I'm not totally at fault" or "I can make up for my mistake" or "I'm not in control" or "I'm responsible and I can and will change in the future." See Kaufmann's suggestions below. Frankly, while it is very commendable to feel self-responsible, to reduce excessive guilt there are special times you may need to blame someone else, your background, your circumstances, chance, or anything but you (see method #4 in chapter 14).

If your expectations of yourself seem to have been unreasonable, decide what are reasonable and fair expectations and tell yourself that your feelings of guilt have been excessive and harmful. Remember, how bad you have been in the past is not nearly as important as how good you are going to be in the future.

Kaufmann (1973) says, first, *it is impossible to know what is just or fair*. Then, second, he says that unless you know or feel certain that you justly deserve to be punished (which is impossible), there will be no guilt. Thus, he reasons, since few people can be certain they deserve punishment, there is no justification for guilt about past deeds. This seems like a weird notion to most people, but think about it. Kaufmann recommends we replace the useless, harmful guilt we have about the past with a keen sense of social responsibility for the present and the future. That makes sense. Note the difference:

Past-oriented
(guilt)

Future-oriented
(responsibility)

my guilt=my badness *vs* my fault=my responsibility
 remorse=self-torture *vs* regret=wish to change things
 contrition=anguish *vs* humility=ambition to do one's best
 "It should have been" *vs* "It can be better in the future"
 wallowing in past sins *vs* planning future improvements

This is a powerful argument for focusing on planning a responsible future, instead of dwelling on your (or anybody's) guilt of the past. It is a way to atone. Don't use it as a way to cop out and forget your transgressions, because this will encourage you to be immoral again.

So far as science knows, *there are reasons for everything*. All behavior is potentially understandable (if we knew all of the cause and effect laws). A determinist would say that all behavior (thoughts, feelings, *and* acts) is the natural, inevitable, "lawful" outcome of past experience, environmental influences, and inherited or physiological factors. Thus, *if* all behavior, no matter how saintly or how evil and including our "awareness," our "cognition," our "will," and our "choices," is determined by historical and outside influences, how can we--our conscious selves at the moment--be totally responsible for everything we think, feel, and do? If we (our conscious selves) aren't totally in control, then we aren't entirely responsible or guilty.

Imagine someone else was "in your shoes," i.e. had your body, your family background, your memories, your knowledge, your needs, your dreams, your friends, and environment, would they do, think, and feel as you do? I think so, just as you would be them if you were in their shoes. ("There, but for the grace of God, go I.") You are uniquely you because of all these historical, environmental, and physiological differences. The laws of behavior are the same for everybody; only our experiences, environment, and bodies vary. At

any one moment in our lives, we can't change our past experiences. We can change (modestly) our future experiences, however. I think determinism, although it may seem weird to you at first, has a lot to offer the overly guilty and the overly critical person--see method #4 in chapter 14 for more.

Suppose you decide you have done something immoral--something inconsiderate and hurtful. It is possible to regret that action, to believe it was ethically wrong, without feeling terribly guilty. If, as Kaufmann suggests, however, you assume responsibility for your mistakes (no one else can), you can now plan the future so that you make up for your wrongdoings. As in 12-step programs, you can atone; you can right the wrongs (see Mowrer, 1975). There are some cautions: guard against doing things that would re-open old wounds in others, just to relieve your guilt. Don't "confess everything" as a way to get punished or to "get it off your chest," if the information could seriously hurt others. Don't assume there is no way to make up for the past. Even if the person you hurt is dead, you could make an appropriate sacrifice to someone or to society as a substitute.

If your excessive guilty feelings are associated with remembering what you did with certain people, one could use desensitization to reduce the guilty response, just as if it were an unwanted fear response. See chapter 12.

Suppose, as will often happen with unhappy people, you feel bad or sad or unworthy but can not pinpoint any particular immoral behavior (or thoughts) that might have caused your negative mood. The big "sins" in our society are anger and sex (see chapters 7 and 10). Look there first. Next, look for anger or guilt towards the people, usually parents, who may have taught you to dislike yourself. Also look into old relationships in which you hurt someone or were hurt, especially divorce or infidelity. Remember that many women cry instead of allowing themselves to feel rage. So, if you cry a lot, look for repressed anger. Next, look inward for guilt about not helping others in need (chapter 3). Lastly, as discussed in the section on self-criticism, check to see if you could be using guilt to manipulate others. And, ask if others might be laying a "guilt trip" on us. Increased awareness of all these possible factors could help you understand your guilt and cope with it.

Useful readings about guilt include Madow (1988) and Preston (1989). Freeman & DeWolf (1990), Freeman & Streat (1995), and Klein & Gotti (1991) help us handle regrets of our past and fears of doing something in the future we will regret. Don't forget to atone and ask others for forgiveness (see chapter 7). Don't forget to forgive yourself (Flanigan, 1996).

Shame

As discussed in cause #13 of depression, shame is one part of our self evaluating the other parts of our self and concluding that we have serious faults, so bad we should be ashamed. You judge yourself to be inadequate or unworthy or defective. You feel defective in a way you wouldn't want anyone to know about, so you hide your defects by pretending to be different; you create a false self to show the world in place of the embarrassing true self. Alice Miller calls it "soul murder" because you kill or disown a real part of you and start hiding behind a mask, fearful your faults will be "found out." If we can not accept what we really are, we are driven into a lifetime of deception, self-rejection, and suffering. Many serious psychological problems are caused by this kind of self-destructive, *unhealthy* shame.

Toxic shame screams at us that we are worthless; *healthy* shame gently reminds us of our limitations and faults. With healthy shame we aren't happy to have these embarrassing weaknesses and defects but this awareness is healthy. It keeps us in touch with reality--and it keeps us humble. A modicum of self-doubt also keeps us open-minded and searching for better understanding. In this section, we are concerned with the more serious unhealthy or toxic shame.

Toxic shame comes from toxic parents, according to Forward (1989). For instance, if a child is forcefully told that his/her anger is bad, a terrible way to behave, really shameful, disapproved of by God, etc., that child is going to learn to inhibit anger because toxic shame is felt every time he/she gets mad. Eventually the anger is disowned and denied; the child doesn't even reveal the angry feelings to him/herself; it is repressed. Yet, the child, like everyone else, is still frustrated and disappointed. The anger still exists within the alienated or hidden parts of the self and generates energy. This loss of part of the self and the presence of denied (unconscious) emotions must create a very confusing experience for the child, no wonder he/she feels helplessly out of control. More and more of the self (needs, emotions, actions, thoughts) become shame ridden, even contemptible. You feel more and more flawed. The self feels it must escape from itself, this is done by creating a false self.



A guilty person fears punishment and wants to make amends. A shame-based person wants to be punished.

-John Bradshaw



John Bradshaw (1988) points out that the false self will be different from the true self but in either a positive or a negative direction, e.g. you may begin to develop a self that is very neat and tidy

(perfectionist?) or go in the direction of an untidy slob, you may come to see yourself as the family hero (caretaker) or the family scapegoat (black sheep), you may start heading towards "religious-prudish" or "rebellious-crude" roles, you may shift your anger to being an aggressive, domineering leader or to being a passive doormat, or you may develop a false self of a highly successful achiever or a worthless addict. Thus, Bradshaw says there may not be much difference between the obsessive workaholic CEO and the alcoholic in the alley. Both may be addicts suffering from toxic shame; both have created a false self to hide some awful "hole in their soul."

Unhealthy, destructive shame is the cause of many kinds of addictions and compulsions. Because we feel defective, we seek something that will make us feel better--many of these activities become destructive compulsions in the long run. Examples: *drinking* temporarily helps us forget, get courage, and feel better; *working hard* diverts our attention from pain, reduces our anxiety, and produces results; *over eating* relieves many unpleasant feelings and occupies our time and mind; *sex addiction* provides a preoccupation, challenges, and "fun;" *over spending* feels good until we get the bill, etc. In short, there is a cycle: (1) I'm defective and unlovable, (2) since no one could love me as I am, I must be different or I need something--the addiction--to make me feel better, (3) Wow! This works (getting drunk, making lots of money, fixing a great meal, picking up a hot date, etc.), (4) paying the price (hangovers, being divorced, getting fatter, getting AIDS, bankruptcy, mental breakdown, etc.), and (5) I was right, I am a terrible person--back to (1) again and start over.

Exercises for understanding and reducing shame

If you think about it, you can see that for an addict, the problem is not really the "acting out" or addictive behavior. In fact, the addiction is the addict's *solution*. As the alcoholic says, "my best friend is the bottle." For the addict, the eating, spending, working, using drugs, drinking, orgasming provides relief from the inner emptiness--the "hole in the soul"--and escape from facing the shameful defects felt by the 4-year-old inner child. The addict vaguely (and erroneously) senses his/her problem is his/her being inherently, unavoidably defective; thus, there seems to him/her to be no solution (except for his/her "habit"). And, in line with this defeatist notion, AA teaches "I am powerless against my addiction; I must turn to a higher power."

Is there no solution for toxic shame or for compulsive habits or addiction? Bradshaw says, "...there is no way to change your *being* by your *doing*." He means that you can be highly successful--rich, president, an Oscar winner, etc.--but the toxic shame, the inadequate feelings, the "I'm bad" feelings, the "hole in the soul" will remain the same. So, what will fill the hole and reduce the shame? Bradshaw is certain it involves sharing your faults and feelings--all those things you've had to hide--with accepting and supportive others. That is exactly what happens in therapy, support groups, and 12-step groups.

In groups or some other way, we have to remember the hurts and re-live the "original pain" that made us feel ashamed. Self-help methods might help too.

One emotional technique Bradshaw uses is *writing a letter to your parents telling them what hurt so much when you were little and what you needed that you didn't get*. As part of the uncovering and grieving of our childhood, we come in contact with our "inner child" (the 4 or 6 or 8-year-old inside each of us). Another powerful technique is to go back (in fantasy) as an adult to your childhood and find and get re-acquainted with your hurt, scared, needy inner child. Then tell your inner child you are going to take him/her away from the hurts of the childhood home, that you will always take care of him/her, never hurt or leave him/her alone, and always attend to and love him/her. Then, *do these things* for your inner child; this is starting the process of accepting and taking care of your true inner self. Group acceptance also reduces our shame; recognition and acceptance of our shamed inner child by ourselves and by others help heal the hurting inner child.

Within individual or group therapy, many other techniques are recommended. Examples: we need to own our disowned parts (or "voices"), i.e. to become aware of and accept all our previously rejected emotions, wants, and needs. One way to do this is to think of the 6 or 8 people you most dislike-- they often represent your own disliked parts! You have probably over-identified with the opposite traits, i.e. if you dislike a pushy, rude person, you are probably prone to see yourself as being and try hard to be a nice, polite person. As a child, you may have disowned the pushy, rude jerk part of yourself. So identify the traits you dislike in these 6-8 people and consider if you think of yourself as similar or different from them in these ways. Since you may be using lots of energy keeping the disliked internal voices quiet, have a silent conversation with each of your 6 to 8 disliked parts (based on the people you dislike) and get the views and reactions of each. For instance, see what your pushy, rude part has to say about your overly nice, quiet, passive, mousy, doormat part. For you as a 4-year-old, the demanding rude part was probably a problem; try to see how you handle it now. If you can get in touch with a negative part and it feels like it might be part of you, accept it back, get in tune with it, and learn from it. Don't act on the pushy, rude part necessarily, just realize the brash, self-centered, demanding, tactless part still exists inside. Make yourself whole again by becoming aware.

Bradshaw also suggests using self-esteem building techniques (chapter 14), self-acceptance (chapter 14), assertiveness and communication skills (chapter 13), desensitization and visualization to reduce shame (chapter 12), cognitive methods to stop irrational ideas and false conclusions (chapter 14), dream analysis (chapter 15), and others. I agree that those methods might help.

Bradshaw's dilemma is that he says that more than half the people in the world have a compulsion or addiction involving eating, drinking,

achieving, being perfect, intellectualizing, sexually relating, shopping, trying to look attractive, cleaning, rescuing, or some other habit. Many of these people suffer from shame. But, supposedly, according to Bradshaw, shame can't be cured without years in a 12-step program *plus* long-term Psychoanalytic psychotherapy in which (a) an emotional bond is established, (b) the old hurts and repressed parts are uncovered, (c) the inner child is nurtured and protected by the adult, (d) false beliefs and irrational ideas are challenged, (e) the images and voices that convince us that we are weak and unworthy must be replaced with optimistic ideas, and (f) we must have a "spiritual awakening." That is a lot of therapy for two billion people or so. Bradshaw is, nevertheless, right to emphasize the importance of preventing shame (see *Bradshaw On: The Family* on PBS). And, although the psychoanalytic theory sounds good, we need to look for more efficient and effective therapies.

Perhaps (it is an empirical question) some or much of this therapy can be done by ourselves. Pollard (1987) recommends "self-parenting" which consists of learning how to support, nurture and love your "inner" child. Another of the early and more original writers about shame, Gershen Kaufman (1992), says that an effective antidote to shame is caring, warm relationships. People bothered by shame need to be loved and accepted, *and* they need to give to, care for, love, and relate warmly with others. Helping others is good self-therapy too.

Boredom, apathy, and tiredness or exhaustion

Boredom, a lack of interest, tiredness, and the "blahs" are signs of silent depression. Millions of us are bored with work, school, marriage, etc. Why are we so bored? First, maybe we just aren't doing anything interesting or challenging. The Greeks defined happiness as doing one's best and using all of one's potential. That seemed like the problem for Judith Hennessee, a popular writer, who has described her discovery of boredom. She was an active wife and mother, busy in community activities. One day she noticed all her days were alike. She wondered if this was all there was going to be to life. Then she suddenly realized, "I'm bored out of my mind and don't even know it." It seemed like she was missing her life. It was terrifying. She had always wanted to write, so she started. She felt happier and more fulfilled. We all want to do what we are good at doing. Second, even demanding work can be boring if you have no autonomy and simply "follow the rules" made by someone else. We need to feel "in charge" of something; we need to be flexible, adapting to the situation; we need to use our judgment. Third, even challenging work involving decision-making can be boring if we do not consider the work worthwhile and commendable. Life must have meaning. Otherwise, we burn out. Cherniss (1995) studied burnout during the first 12 years of being a social worker, teacher, therapist, nurse, or lawyer. He shows how these professionals sometimes recover from it.

Therapists frequently ask their clients what he/she see him/herself doing in one or five years. Or, what would you do if you had only three

days to live? These ways of asking people about their ideals or dreams can be consciousness-raising experiences. We need to believe there is a connection between our activity today and our hoped for payoffs in the future.

How is it possible to get bored in a complex, intriguing world? There are some theories: if you add positive and negative feelings together, the result sometimes is "nothing"--an indifferent, blah feeling. Examples: after living with a lover a long time, the positive and negative emotions may combine to produce "no feelings" or a "taken for granted" feeling. A rebellious person may combine the pleasure of expressing anger with guilt and feel indifferent or "I don't care." A student may like some parts of school and dislike others and feel apathetic. In short, apathy may conceal intense and disturbing feelings. Schaefer (1973) illustrates this further: a dying person welcomed boredom because it made life seem longer. Another person, although prudish, was persuaded to watch two friends having sex; her reaction, "I was bored." Each feeling needs to be recognized and dealt with, not denied or repressed. Most of the time, though, we're bored because "there ain't nothin' to do," as we see it.

Another interesting observation is that we become bored *at* something: "the lecture is boring," "I'm bored with reading," "we are bored with each other," "my work is boring," etc. One implication is that "I'm not responsible for the boredom, I'm the victim." Another is that "someone else is doing this to me," and things would be okay if I could get away from them. This certainly hints at both anger and helplessness.

Almost one quarter of Americans report being fatigued for longer than two weeks. It is among the top 5 complaints to doctors. Stress and burnout make us tired (and harm our health). Some people respond to sudden challenges with extreme surges in blood pressure; medicine can help. Most tired people need rest, sometimes with an intimate other and sometimes completely alone. Comfortable companions--friends, dog, cat, or therapist--are usually soothing. If one can avoid hostile, demanding people, it will help. Likewise, reading, exercising, watching TV, conversing, bathing, and doing anything fun will lead to inner peace. If you can't merely walk away from the stress, you can change your view of the situation: meditate, realize "it ain't awful," "I can handle it," etc.

One of the more debilitating disorders is chronic fatigue syndrome because the lack of energy and tiredness can become overwhelming. Half a million Americans feel seriously fatigued all the time. Sometimes this fatigue is combined with some serious physical problem--arthritis, colitis, multiple sclerosis--and must have medical attention. Sometimes it seems to be more a psychological reaction which can be helped with therapy or self-help. There are several good references for chronic fatigue syndrome, including Friedberg (1995), Lark (1996), and Berne (1995).

Finally, some therapists (Cammer, 1969) think the body just runs out of energy, causing us to feel depressed. Maybe all feelings are repressed along with the painful depression, producing a lack of interest in anything. Furthermore, lethargic disinterest means we don't have to try new things, take risks, meet challenges, or express feelings. Like all other behavior, apathy has its payoffs. Hoffman (1993) attempts to explain and correct "feeling tired all the time."

Considering all the good one can do and all the fun one can have, it seems sad to live life bored. Make your work into play (Csikszentmialyi, 1975). Most of the techniques for depression would work on boredom, but specifically try these ideas: make some changes in your life, find something valuable and important to do (volunteer to a hospital or a school), take an interesting course, exercise, use your brain to think of self-help projects to do, get active--DO SOMETHING. If there is some irritation with the person or situation boring you, with a little tactful ingenuity you can probably change the situation. Examples: turn the mundane chore into a competitive game, simply tell the other person you are bored (they probably are too), or figure out what is irritating you and change the situation or your thinking. Most of the time, the solution is not just finding some way to fill one afternoon but finding a worthwhile, exciting purpose for your life (chapter 3) and developing self-esteem and self-efficacy (chapter 14).

Methods for Coping with Depression

We have seen that sadness, hopelessness, loss, low self-regard, loneliness, guilt, and shame are complex conditions or processes. The causes are complex and so are the solutions. It is hard to pull yourself out of a sinkhole of misery, sometimes impossible. When you feel most like doing nothing, you need to DO SOMETHING! When the future looks most bleak, you need to face it with some hope. When hating yourself, you need to accept what you have been and work on being better. So you may need help--therapy, medicine, family counseling, and/or religious faith. But, eventually, no matter which "cure" you take, you will have to help yourself; there is no effortless, magical cure.

Throughout this chapter we have seen the wide-spread and devastating nature of depression and sadness. About 20% of us Americans are significantly depressed. Within that 20%, there are about 10% of us who will suffer a *major* depression within our life times. Major depression means you are so sad, tired, and debilitated that you can barely get through the day, you don't connect with other people, and you often have a lot of physical, eating, and sleep problems. With major depression, you may also be weighed down with guilt, hopelessness, worthlessness, and feelings that life just doesn't seem worthwhile. Until this happens to you, it may be hard to imagine. You may be especially frightened because you don't know what to do to feel

better. Severe depression can be over-whelming. It is easily seen by relatives, friends, and doctors—and they also feel helpless.

Moderate degrees of depression are often missed by families and doctors. These people are generally unhappy, have trouble sleeping, feel tense and overloaded, fret about many worries, lack energy and often lose interest in work, friends, current events, sex, and so on. They sense something isn't right because they often medicate themselves with pills from the family doctor or with drugs from the street as well as alcohol. But they don't know what to do about their moods and are reluctant to see a psychiatrist or a psychologist or a therapist. The life time risk of moderate depression is 25% for all women and about 12% for all men.

A discussion of more specific types of depression is given in Chapter 9. There are dysthymic disorders, bipolar disorders (manic-depressive), adjustment disorders, depression associated with physical or medical problems, seasonal affect disorders, and DDNOS. And just grouchy pessimists.

What age group is the most depressed? At this time it looks like it is going to be the "Baby Boomer" generation. We don't know why depression is so common. That generation grew up in good economic times, had two loving, "involved" parents, had only one or two competing siblings, and certainly had far better educational opportunities than any previous generation. People born between 1945 and 1960 also had the best ever medical care, including pediatric care and school counseling when young and in their adulthood they had an array of tranquilizers, anti-depressive medications, and psychotherapies prescribed by attentive psychiatric/psychological doctors. This same generation in their youth was involved in world affairs and actually responsible for fantastic social changes—civil rights laws, voter registration, resistance to the war, improved and equal education, equal rights for women, and so on. I consider them the greatest generation, certainly in terms of righting social injustice. Yet, depression hits them in middle age. Why? We don't know. Their own middle-class, advantaged children (born 1970-1990) will be studied; perhaps they will be depressed too. Maybe one price of unfairly having more than others is depression. Maybe having high expectations increases the chances of failing for some people.

A major revolution in the treatment of depression has occurred after 1990 or so when drug manufacturers started massive ad campaigns urging people to go ask their doctor for a certain drug. This was highly effective (in terms of selling drugs) and the medicalization of the treatment of mental illness may have reduced the stigma of having a psychological or emotional problem. It also reduced the self-blame and the parent-blame for such problems. These are healthy changes, but the implication that depression (and other psychological disorders) is strictly a physical disorder—a brain disorder—is unfortunate. Just because depression can sometimes be reduced by drugs doesn't mean depression is caused by chemicals. How to use antidepressants is covered in the next section.

The research is clear. The combination of medication (taking special precautions with children and teens) with psychotherapy is usually the best treatment for most depression. The rationale is that anti-depressive medication will improve troubled thinking, increase energy and optimism, and

so on, making it possible for psychotherapy and self-help efforts to offer ideas for coping with the depression and its causes (childhood experiences or currently distressing situations).

No one should be ashamed of being depressed. But we are. As Kathy Cronkite (1994) points out, people who openly discuss going to Betty Ford's Clinic for alcohol abuse will carefully conceal their depression. About 1 in every 10 of us will be seriously depressed sometime in our lives. Baby boomers are having even more episodes of depression, perhaps because the high hopes of the 1960's were crushed by the economic troubles of the 1970's and beyond. Remember, there is serious depression which is beyond ordinary sadness; in this condition you may have no appetite, no pleasure, no energy, no hope. And, there is being "down" or in a bad mood for a few days; it may involve crying, social withdrawal, being irritable, having no ambition, being pessimistic, etc. These two conditions are probably two different things. Both should be treated but the really severe major depression must be *taken very seriously*, 15% kill themselves, many more attempt it. Depression is not your fault; you are not a terrible or hopeless person. Unfortunately, 70% of people suffering depression never seek treatment. Please be among the 30% who go for help *and stay with it*. Depression is one of the most treatable emotional problems--psychotherapy can help you, drugs can, and you can. Cronkite's (1994) book offers hope by interviewing many famous people who have overcome the disorder--Dick Clark, Joan Rivers, Mike Wallace, Rod Steiger, Jules Feiffer, and many others.



Note If your depression is *serious* (disabling or suicidal), seek professional help *immediately*. If you are in therapy or a group, be sure to tell the therapist how much you are hurting. If not in therapy, call a therapist or your mental health center. Do not delay by trying to treat yourself or by hoping you'll get better. Serious depression and manic-depression seem to have genetic, hormonal, and/or chemical aspects that are activated by stress and upsetting life events and thoughts. Thus, when the depression is serious, you always need to be evaluated by an MD, who will decide if you need medication. You also need to get psychotherapy.

If your depression is primarily chemical, psychological coping techniques are useful but not sufficient. Likewise, if your depression has psychological causes, drugs may be useful but not sufficient. There is usually no way to tell if your depression is chemical or psychological, so consider both.



If you've read parts of the chapter relevant to you, you probably already have some ideas about how and why you have responded with sadness. Therefore, certain self-help methods in this section will seem more appropriate for you to use. Fine, try two or three and see if they work. If not, try something else. In general, gaining some optimism about getting better, having an easy going disposition, and utilizing family support, along with selected self-help methods, will lead to a better recovery from depression.

The methods for depression are arranged by levels in this section. Quickly read or skim the entire list of methods before you select a few to use. This is a preview:

1. Behavior--increase pleasant activities, avoid upsetting situations, get more rest and exercise, use thought stopping and reduce your worries, atone for wrong-doings, seek support, and use other behavioral changes,
2. Emotions--desensitize your sadness to specific situations and memories, vent your anger and sadness, try elation or relaxation training, etc.,
3. Skills--learn social skills, decision-making, and self-control to reduce helplessness,
4. Cognition--acquire more optimistic perceptions and attributions, challenge your depressing irrational ideas, seek a positive self-concept, become more accepting and tolerant, select good values and live them, and
5. Unconscious factors--read about depression, learn to recognize repressed feelings and urges that may cause guilt, explore your sources of shame (perhaps even going back to childhood).

The Use of Anti-depressants

Anti-depressants have been a major part of the pharmacological era in psychiatry. In the last twenty years, psychiatric practice has changed in major ways, namely, the shift from talking to giving pills. Many factors have contributed to this treatment revolution: (1) the development of safer drugs with fewer side effects, especially the SSRI anti-depressants. These medications may not reduce depression better than older drugs but they are less likely to kill you when an over-dose is taken. (2) The pharmaceutical companies have advertised intensely, turning consumers into drug advocates and permitting drug sales representatives to target primary care physicians rather than the much more rare psychiatrists. Moreover, (3) HMOs have realized their profit-margins can be greatly increased when the drugs are dispensed by a family physician requiring only brief and occasional follow-up visits rather than by expensive psychiatrists. The distribution of drugs got much easier: just tell your regular doctor that you have been feeling down or tired and have had some crying spells, and you immediately get a prescription for anti-depressants paid for without question by your health insurance. Millions have started taking anti-depressants and while they may have shifted from one brand to another, many have been satisfied. Nevertheless, it is generally recognized that anti-depressants take about 30 days to work and about 30% of depressed patients get little benefit from anti-depressants.

During the last two decades, the stigma against taking psychiatric drugs seems to have been considerably overcome but the stigma against “seeing a shrink” (psychological or psychiatrist) is still strong. Moreover, while Cognitive-Behavioral therapy has developed during this period, it hasn’t had a breakthrough in terms of highly publicized effective techniques or in terms of cheap or easy treatment. In other words, anti-depressant drugs haven’t had a lot of competition. Also, most people do not realize how little training and experience primary care doctors, in general, have in dealing with serious psychological disorders, including depression. Yet, as you know, if you have read the rest of this chapter, depression is a very complex and potentially dangerous disorder. It isn’t something to be diagnosed in a few minutes. Since anti-depressants take 30 days before having full impact, a significantly depressed person needs frequent and careful monitoring immediately and during the first several weeks. The treating physician needs to get a detailed mental health history (mental problems or illness often accompany depression) and he or she should strongly encourage the patient to also get psychotherapy as well as drugs. Depression is not an easily treated disorder. The doctor/therapist should be expected to maintain long-term contacts with their depressed patients, at least every week for a few months and maybe much longer. Depression frequently comes back.

Ideally, a health care service for depression would have enough coordinated psychiatric and psychological specialists to carefully diagnose each case of depression, assessing the possible psychological, personal, circumstantial, interpersonal and physiological or genetic causes of the disorder. As a part of this evaluation there should be a careful assessment of the risk of self-injury (see earlier sections of this chapter). This initial evaluation is not a trivial frill; it is crucial. This process should usually involve psychological testing and a detailed history as well as medical tests. The general practitioner is not this kind of specialist. (Light cases of depression could, I suppose, be handled more casually—but how can anyone identify a light case just by talking to a person for a few minutes?)

Another serious problem is that the general public has NOT understood or paid close attention to the research about the frequency of suicide and the obvious connection between depression and suicide. For instance, we often don’t like to think about suicide as being an integral part of depression. Suicide is the eighth leading cause of death in the US. It is the third leading cause in 15 to 24-year-olds and the fourth most common cause of death between ages 10 and 14. This is serious—60% of high school students have had thoughts about killing themselves, 9% have tried. At every age, especially in old age, depression must not be dismissed and taken lightly. The *“just take these pills and call me in three months”* is not acceptable treatment. See the [Suicide section](#) of this chapter (http://www.psychologicalselfhelp.org/Chapter6/chap6_61.html) for a comprehensive review of this field of research

Not only has the risk of suicide underlying depression been taken too lightly, the generally positive public opinion about the effectiveness and safety of anti-depressants seems to have a major disconnect with the scientific evidence. There have been many, many studies. Of course, some of the studies have shown anti-depressants to be effective, sometimes. These drugs,

however, are big sellers--among the best-selling medicines in the world, with such names as Prozac, Serzone, Wellbutrin, Zoloft, Remeron, Celexa, Effexor, Lovox, Paxil, and others—all similar in chemical composition. The total sales world-wide are about 20 billion dollars per year. In 2002 alone about 11 million prescriptions were written just for children and teens in the US. Let's think about why is it difficult to honestly know the effectiveness of anti-depressants (or any other treatment).

People come to see doctors and therapists because they are feeling badly, often their discomfort has gotten gradually worse, and they are seeking help at the height of their depression. If so, the chances are (for a variety of reasons) that the problem will later get better rather than staying awful or getting worse. This amelioration process is observed so often when scientists re-assess unusually high or extreme conditions; this going back towards normal (for you) is called "regression to the mean." So, you see a doctor with a bad cold, an aching back, a tension headache, etc., and soon in the natural course of things you begin to feel better (closer to average for you).

There is another process that also makes it hard to evaluate the effectiveness of a treatment method—the suggestion or placebo effect. It is well known that a sugar pill can help many people feel better (if the doctor suggests it is very effective medicine and will take care of the problem in a couple of days or weeks). If such a suggestion is made or just implied when actual medication is given, then the placebo effect and the drug effects combine together and both may be working. To prove the effectiveness of a drug (or any treatment) the amount of improvement shown to be due to the drug alone has to be significantly greater than the placebo effect by itself. Note: according to testimony given in the fall of 2004 to the Congressional Energy and Commerce Committee, about half of all studies of anti-depressants have not shown in adults that the SSRI drugs are significantly more effective than a placebo alone. Even worse, insignificant results were found in two thirds of the studies in which children were given anti-depressants and compared to children given a placebo. This is not well understood by the general public. Please note that these research findings certainly do not prove that anti-depressants are entirely ineffective (in fact, half the studies may suggest anti-depressants yield some benefits), but these results cast considerable doubt on the effectiveness of the drugs. Psychiatrists know the effectiveness of anti-depressants is limited; they commonly point out that anti-depressants do not help about 1/3 of their depressed patients.

In addition to these difficulties interpreting the results of research, more recently there is a new and very disturbing possible problem with using anti-depressants, especially with children and teens. Over several years, there have been occasional clinical reports of suicide and violence associated with taking anti-depressants. For instance, it was reported that Eric Harris, one of the suicidal shooters in Columbine High School, had been taking an anti-depressant (Luvox). Parents have described the sudden, out-of control suicide of a college student after taking a regular dose of anti-depressants (<http://www.nypost.com/news/nationalnews/30505.htm>). Britain prohibited prescribing anti-depressants to children and teenagers in late 2003 (a year before the US considered such action). Even more alarming, Shankar Vedantam of the Washington Post reported on September 10, 2004, that testimony was given at a congressional meeting that two internal FDA

analyses showed that anti-depressants, given to children and teens, were associated with increased suicidal thoughts, actual self-harm, and hostile behavior. How much of an increase? FDA recently estimated that these drugs might double the risk of suicide in children. While the rate of suicide at that age is low, this sounds very serious. Other analyses by FDA reportedly indicated that the risk of suicide in children taking anti-depressants was only 2% or so greater than in children given a placebo. However, FDA also reported that children taking Effexor had almost 9 times the risk of suicidal behavior or thinking (also reported in Washington Post). These are much higher risks than most families would be willing to run, until science tells us more about identifying the children most at risk taking anti-depressants. We lack the accurate useable facts that we need. Any treatment causing deaths or near deaths is a serious matter that will probably have far-reaching effects on the treatment of depression. So, much more research is needed.

The difficulty of predicting suicide is discussed in some detail in the earlier [Suicide section](#)

(http://www.psychologicalselfhelp.org/Chapter6/chap6_61.html). The suicide prediction problem is an important part of the decision to use anti-depressants or not. Also, the patient and his/her parents, if a child or teen, should be involved in the tough decision-making about the use of drugs. It isn't just a question of what approach offers the most hope for improvement but also what methods have helped and not helped before and how desperate the situation is. If I am feeling terribly miserable, I'd be willing to take more chances with a risky drug..just the same as when risky surgery is an option.

Please remember I am not a physician. I have no expertise concerning drugs. My review is just a summary of the relevant available research which suddenly seems very important. The data and my comments should in no way be interpreted as opposing the use of anti-depressants. There probably are many circumstances in which it is a very good judgment to give anti-depressants to children and teens. This new information about anti-depressants with children just makes it critical that case studies and treatment plans are done at the highest level of professional competence.

I strongly recommend each depressed patient (and his/her parents, if the patient is a minor), with the help of his/her physician (the prescription writer), explore the pros and cons of taking anti-depressants. It is not a simple decision. If the prescribing physician is not a psychiatrist or a psychotherapist, then a therapist (Psychologist or Social Worker) should permanently join the team. At this time (fall of 2004), only about 15% of children and teens being treated for depression are prescribed anti-depressants. If research continues to find suicide risks are associated with anti-depressants, surely a number of changes are likely to be made in the treatment of depression. What will change is hard to know until we get better research. For instance, we need to know the rate of suicide in certain types of patients in specific circumstances depending on whether they are taking anti-depressants or not. Science needs to map the high risk points for depressed patients on and off medication. Certain dangerous times have been known for many years, but we need to know more. For instance, Wessely, Kerwin & Kaye (2004) found that the most dangerous times for adults and children taking anti-depressants were in the first nine days of treatment (a four-fold

increase in non-fatal suicide behavior). The risk is three-fold higher during days 10 to 29. What if they were not taking anti-depressants? Another high risk time for children and adults is when anti-depressants are suddenly stopped. It is important that the doctor and the patient know the high risk times so both can be especially vigilant.

In summary, moderate or serious depression carries with it a threat of self-injury. This risk requires special precautions. Taking anti-depressants must be considered carefully because the drugs may slightly increase the risk of agitation and suicide in some young people while the drug may effectively relieve depression in other people. The prescribing doctor, the collaborating psychotherapist, the patient, and the parents of a child or teen should be involved in making the treatment plans. The prescriber and/or the psychotherapist must see the patient frequently, probably weekly for an hour, especially during high risk or high stress or high agitation times. The FDA's concern is high enough that the drug manufacturers and the FDA are now considering adding a suicide warning on every package for children or teens. For unexplained reasons, the news reports describe the manufacturers as being more eager to have a blunt, rather scary label placed on their medications than is the FDA. On Oct 15, 2004, FDA required black box warnings of suicide risks for children and teens to be printed on every box of anti-depressants.

A recent study at the University of Colorado by Valuck, Libby, Giese & Sills (2004) illustrates the crucial need for more research into the risks of self-harm for adolescents taking antidepressants. These researchers followed 24,000 depressed adolescents for six years. The risk of a suicide attempt, in their sample, was not greater for young people given antidepressants than for those not getting antidepressants. Of possible additional significance, the adolescents given antidepressants for at least 180 days made fewer suicide attempts than adolescents taking the drug for less than 55 days. Standing alone, these results are difficult to integrate with the above studies: Do different outcome measures (suicide attempts, near-lethal acts, and actual suicide rates) yield different results? What factors correlate with being prescribed antidepressants? Why did some subjects take medication much longer than others? Were they more compliant patients? The authors suggest that the quality of health insurance may influence what medication one gets, who administers the antidepressant, who gets antidepressants alone, who gets only psychotherapy, and who gets both? Many, many studies are needed to answer these vital questions.

Level I: Behavior (see chapter 11)

Lynn Rehm (1981) has developed a self-control treatment program for depression based on Kanfer's model of self-monitoring, self-evaluation, and self-reinforcement. The first five steps summarize Rehm's methods:

Self-observation

Although depression frequently seems (to the depressed person) to come from nowhere, i.e. isn't related to daily events, that isn't true in most cases. The Lewinsohn research has clearly shown that positive events or activities lead to positive moods; negative events to depression (Grosscup & Lewinsohn, 1980). The depressed person must become aware that this is true in his/her life too. So rate your mood on a 1 to 10 scale (see chapter 2) *and* keep a log or a diary every day of positive events and activities. It is likely that your mood will reflect what is happening in your life.

As we have seen, depressed people tend to focus on negative events and overlook positive ones. They don't know they are doing this. So, it is important that they "give careful recording a try and see what happens." Look for and record all pleasant events and activities, even small, trivial, seemingly unimportant pleasant events. It is vital that you learn, again, to see the beauty, feel the warmth, and smell the roses. Don't forget ordinary things: a cup of coffee, a walk, seeing a bird, reading a book, helping someone, watching kids go to school, watching the news, reading an advice column, going shopping, listening to music, making yourself attractive, visiting a neighbor, completing a chore, calling a friend, daydreaming, playing with children, expressing an opinion, getting a long kiss, getting or giving a compliment, etc., etc. Record in your diary (3 or 4 times each day, otherwise you'll forget them) a brief description of these pleasant events.

After about a week, plot your daily mood rating and number of pleasant events for that same day on the same graph (see chapter 2). See if your mood doesn't go up and down according to how many pleasant events occurred that day. If so, this is a powerful argument to *increase the number of pleasant events* in your life and to appreciate the nice things that happen.

This is a simplified version of a "behavioral analysis" (method #9 in chapter 11) in which one would look for the antecedents and consequences of good and bad moods. The objective is to find cause and effect relationships that can be used to increase happiness and reduce sadness. I would recommend a behavioral analysis because it explores the causes of the depression as well as the sources of satisfaction.

Look to the future

Like procrastinators, when we become depressed we tend to focus on the past or to see primarily the immediate consequences, not the long-term results of what we are doing now. We hurt, so we focus on immediate relief, disregarding activities that might be stressful but very important to our future, like getting training for a new career. To increase your awareness of the effects of your activities, do one "*outcome analysis*" each day of some activity, i.e. estimate the short and long-term, both positive and negative, outcomes. Examples:

<u>Activity</u>	<u>Effect or Outcome</u>	
	<u>Immediate</u>	<u>Delayed</u>
Watch soaps on TV	+Distracting. Fun. +I can tell others about show. -May upset me.	-Shows won't be remembered -I wasted valuable time.
Take a hard class	+Interesting. +Meet people. +Get ideas for current job. -Stressful. -Takes time & money.	+Career advancement. +Adds hours toward a degree. -May be unemployed so class wouldn't help.

The objectives are (a) to encourage realistic, long-range planning, (b) to see the lasting consequences--or the wastefulness--of certain daily activities, and (c) to make some important but uncomfortable activities more tolerable today because they pay off tomorrow. This is important for all of us to do, but it is even more important and difficult for a pessimistic person with low self-esteem to do.

One small step at a time

Earlier we learned that global thinking (or end goal wishing), e.g. "I need to get better grades," overlooks the necessary details of how to get there. Also, unrealistic, perfectionistic expectations, e.g. "I'll get all A's," may lead to disappointment and self-criticism. Thus, it is important to learn to have a plan, to set realistic goals and sub-goals, and to have some success experiences. It is important to be satisfied with small gains. So, decide on some practical, possible, important self-help project--dieting, increased socializing, more detailed and prompt record keeping at work, learning to play tennis, spending more time alone with spouse, or whatever. Then, for each project goal, set several clear, explicit, attainable sub-goals (small steps), perhaps things you could do every day or every few hours (see goal setting in chapter 2). Schedule the time, give it priority, and be sure you are successful. Record your progress in a diary, along with the positive outcomes.

Self-evaluation

When discouraged, we feel at fault when things go wrong and "just lucky" when things go well. Rehm has an exercise to help you realize your contribution to success and reduce your responsibility for failure:

- Think of an important recent event and describe it.

- In what ways were other people, chance, luck (good or bad), or fate responsible for this event?
- In what ways were you (your efforts, skills, abilities, experience, appearance, etc. or lack thereof) responsible for this event?
- What percentage of the responsibility for this event was attributable to you? _____%

Do this for several events, including both positive and negative ones. You have almost always worked for positive events and against depressing events. So, if you do not think you are truly responsible for more than 50% of the pleasant events, reconsider your explanation of those events and see if you aren't causing more positive things than you thought. Factually based confidence in your self-control is a powerful antidote to pessimism and helplessness (remember depressed people underestimate their problem-solving ability).

Usually others or circumstances or just bad luck cause unpleasant events (the exception to this general rule is when our passive-dependency is the cause). So, if you see yourself as responsible for negative events--over 50% of the time--go back and see if others and chance aren't more responsible. If your passivity is the problem, see chapter 8. Ideally, you will come to believe (accurately) that *your* general, stable abilities and traits, e.g. intelligence, personality, organizational, and communication skills, etc., cause good things to happen and uncontrollable, temporary *external* factors that you are not responsible for produce the downers. (You are correct if you are thinking this fits better in level IV. See #29 below.)

Self-reinforcement

Self-deprecating people feel that giving themselves overt self-rewards--going out for dinner--is being selfish, and they think giving themselves covert self-rewards--"I really handled that well"--is shameful bragging. These attitudes become barriers to using some of the most powerful self-control tools, such as self-reinforcement and self-praise (see method #16 in chapter 11). Rehm recommended making a list of assets--true positive traits. Read it frequently and add accomplishments to it. Make another list of possible rewards, as in method #16 in chapter 11, and use them in self-help projects. Depressed people need more good things in their lives.

Get active. Actually, research has shown that we do fewer fun things when we feel low, but simply doing more pleasant activities is no guaranteed cure-all (Biglan & Dow, 1981). Yet, actions do change feelings. Increase your activity level, get out of bed (or your chair or house), find interesting, fun things to do but, more importantly, undertake profitable, beneficial activities that solve problems, improve your situation or future, and replace sad thoughts. Start with easier tasks, work up to harder ones. Reward your progress.

Several therapists recommend that every major activity on your daily schedule be rated for "mastery" (how well you did it) and for "pleasure." From these ratings we can learn a lot, e.g. that we are getting more pleasure than we thought out of life, that we can do many things pretty well, that many activities are satisfying even though we aren't very good at them, and so on. You may have to push yourself to be active. A book by McGrath (1994), stressing converting depression's dissatisfactions into motivation to self-improve, could also prod you into constructive action. Examples: feeling like a victim may lead to correcting the situation, anguish about aging may encourage exercising, a poor evaluation may inspire us to learn more, etc. Deep depression makes it very hard to get active (in those cases medication may be needed).

Exercise promises long-lasting results. In just the last couple of years, there have been a couple of interesting studies showing that an aerobic exercise program--stationary cycling or treadmill--for 30 minutes 3 times a week reduced major depression as much or more than medication (Zoloft). After 16 weeks, the remission rate was 60% for both groups, but at follow up after another 6 months the exercise group had a higher recovery rate (than the drug group) and they were less likely to relapse (8% vs. 38% in the Zoloft group). The subjects in this study were middle-aged or older (Babyak, et al, 2000). Be sure to check with your doctor first, but exercise would be good for you in many ways, not just with depression. Seriously consider this. Even more recently, other studies report that daily exercise reduces depression by 1/3 or 1/2 within 10 days, which is faster than most people respond to anti-depressive medications.

The data keeps coming in. Please pay attention to this. Another well done study (Trivedi, M., January, 2005, *American Journal of Preventive Medicine*) shows that exercise alone three or five times a week for 30 minutes reduces depression by about 50%. That is as good as taking antidepressants or as good as getting Cognitive-Behavioral psychotherapy. The study observed mild to moderately depressed 20 to 45-year-olds.

Avoid unpleasant, depressing situations. Take a vacation, get complete rest and lots of sleep (just for a week or two--not for months). Our interpersonal situation powerfully influences our happiness and depression. Barnett and Gotlib (1988) found that introversion, loneliness, dependency, and marital problems often precede the onset of depression. Avoid losses and these conditions if you can (of course, it can be a joy to lose a lousy marriage).

Change your environment. Try to change your depressing environments --working conditions, family interactions, stressful relationships and so on. Our mood reflects our surroundings.

Reduce negative thoughts. Reduce the negative thoughts that characterize depressed people: self-criticism ("I'm really messing up"),

pessimistic expectations ("It won't get any better"), low self-esteem ("I'm a failure"), and hopelessness ("There's nothing I can do"). How do you stop or limit these depressing thoughts, memories, or fantasies? Try using *thought-stopping*, *paradoxical intention* (massed practice) or *punishment* (chapter 4). Or restrict unwanted sad thoughts to specific times or places, e.g. a "depression" chair; then reduce the time spent in the chair (see McLean, 1976). Or reward stopping negative thoughts; replace them with pleasant fantasies (Tharp, Watson & Kaya, 1974).

Have more positive thoughts. Make an effort to have a lot more positive thoughts: satisfaction with life ("Living is a wonderful experience"), self praise ("I am thoughtful--my friends like that"), optimism ("Things will get better"), self-confidence ("I can handle this situation"), and respect from others ("They think I should be the boss"). Even if you don't feel like saying these things every hour, say them anyway. They will become part of your thinking.

Ask others to model for you how they control depressing thoughts and guilt producing ideas. What self-instructions do they use to "get out of a bad mood?" Practice talking to yourself out loud, then silently. See method #2 in chapters 4 and 11.

Become aware of any payoffs for depression or self-putdowns. Reduce these reinforcements: don't complain or display sadness, ask others to ignore your sadness (but interact with you more during good times). Remember excessive talking about your depression may sometimes make you more depressed (don't use this as an excuse for not seeking help).

Act happier. Practice smiling more, speaking in a less whiny voice, standing up straight with chest out, dressing up more and expressing compliments, feeling self-satisfaction, and acting as though the future will be better. Acting happier can change our mood.

Become a better self-helper. Become a better self-helper as you work on a variety of personal problems (Rehm, 1981). Learning to master a life--*your* life--is not easy. Read self-help books. Use the steps in my chapter 2 to make some self-improvements. Prove to yourself that you can change your environment, your behavior, your mood, and so on. Recognize your increased ability...but know your limitations. Both knowledge of useful psychology and self-confidence are important. Feeling in control of life is an important part of enjoying life.

Atonement. Figure out a way to make up to others or to society for the things you have done wrong (see discussion of guilt above).

Develop marital contracts. Develop marital contracts that provide each partner with a reward for changing in ways requested by the mate. See method #16 in chapter 11.

Seek support. Self-Help or Support Groups, Marriage Enrichment Programs, Parents Without Partners, Integrity Groups, Singles Groups, Emotions Anonymous, The Compassionate Friends (for bereaved parents), Neurotics Anonymous, Recovery, Inc., Theos Foundation (for widows), Widowed Persons, encounter groups, group therapy, church groups, or local groups of people in similar circumstances. Use the phone book and/or Mental Health Center to find the appropriate group for you (see discussion in chapter 5).

Level II: Emotions (see chapter 12)

Even though tests for depression and anxiety correlate moderately (about .60), most depression treatment programs have neglected anxiety (Biglan & Dow, 1981). This is changing because going through high stress has been found to sometimes trigger the onset of depression. About half the time serious anxiety accompanies sadness and surely anxiety is almost always associated with guilt, shame, and low self-esteem. Biglan and Dow suggest that anxiety increases our tendency to withdraw when depressed. So, avoiding *stress* and reducing *anxiety* may help increase our activity level and decrease our chances of becoming depressed. See chapter 5.

Anger is also frequently associated with depression, especially with marital problems, guilt, shame, and dependency. Likewise, it is speculated that *dependency* and "love bonds" are especially important in women's depression (Scarf, 1979). Women are 2 to 6 times more likely than men to be depressed; they tend to be more lonely and dependent while men are more self-critical. So, chapters 5, 7, and 8 may help cope with sadness too.



Sorrow with his pick mines the heart, but he is a cunning workman. He deepens the channels whereby happiness may enter, and he hollows out new chambers for joy to abide in, when he is gone.

-Author unknown



Use relaxation, desensitization, meditation, and elation training to counteract sadness, worry, anger, etc.

There is clear evidence that high stress increases the risk of getting depressed. So, learning to cope with stress helps prevent depression. Also, if sadness, anxiety, anger, guilt or shame are associated with specific situations or memories, the unwanted emotions could be reduced by desensitization. Example: if feeling sad about being rejected by a graduate school or for a job, one could remember the events leading up to the rejection and to the rejection itself while being very relaxed (see chapter 12). This should make the

rejection less painful (especially if new exciting plans are also being developed).

Desensitization and stress inoculation. If the depressing event is anticipated, desensitization and stress inoculation could be used in advance to reduce the impact. Example: Suppose you suspect that you are about to be fired. Advanced planning of how to handle the situation could help, e.g. requesting that your work be evaluated by an unbiased outsider, offering to work for less, insisting that the decision be taken to the next higher level, or threatening to sue. Also, you can rehearse ways of calming yourself and responding to criticism. Planning or actually starting to search for another job might also be reassuring.

Whenever possible, anticipating, talking with a friend, and "emotionally working through" a loss in advance is usually a lot better way of handling the situation than pretending the loss is not going to happen.

Express feelings. Some feelings can be reduced by getting them off your chest--getting them "out of your system." A good cry can sometimes relieve sadness. Beating a pillow can release rage.

Get plenty of rest. Insomnia, especially waking up early, plagues many depressed people. Relaxation and stimulus control procedures have helped many people get the sleep they need (see chapter 5 and Bootzin & Nicassio, 1978, or Catalano, 1990, or Perl, 1993).

Pursue happiness. Overall happiness is *not* produced by occasional *intensely* positive events but rather by *frequent* mildly positive experiences. Many people feel those pleasant moments must be unplanned and spontaneous but the evidence is otherwise, namely, happiness can be self-generated. How? (a) Focus on achieving *emotional closeness with loved ones*. (b) Find things about *work* that you enjoy and want to work hard on. (c) *Help others*. (d) *Exercise*, doing something you enjoy. (e) Plan to do *new* fun things too. (f) Have lots of nice "moments," not just big highs (Diener, Sandvik, & Pavot, 1990).

The above isn't just the opinion of therapists. Many people who have overcome depression say that the best signs that the depression is over are re-engaging and enjoying the family, finding new career or hobby interests, exercising, and getting involved in community service. In short, they are enjoying life and people again. Anyone who has been depressed realizes it is vastly different from being fully recovered.

For some people, the return of the joys of living seems to automatically occur after getting over the basic physical aspects of depression (feeling really down and tired, loss of appetite, under or over sleeping, lacking interests, negative thoughts, especially of death...). For other people, they need to find hope and to be given

encouragement to seek interesting, exciting, enriching activities in their lives. Many people get some relief from the physical/biochemical symptoms by taking anti-depression medication but full recovery is still a long way away. They may just wait expecting the medications to eventually completely cure their depression, but this may never happen. Many experts, however, believe your full recovery would come quicker if you set about planning and trying to learn how to re-capture the joys of living you want so badly.

There is a new online organization, [GOAL! Go On And Live](http://www.joeant.com/DIR/info/get/10650/30040) (<http://www.joeant.com/DIR/info/get/10650/30040>), which provides help in overcoming depression by seeking satisfaction and meaning in several aspects of your life. Check out the New Patient Survey mentioned on the main page. This survey of patients, who have fully recovered from depression, lists these kinds of efforts that helped them come out of the depths of depression: re-building good relationships with family, finding anew or reviving love relationships and friendships, developing or re-capturing satisfying work or professional roles, contributing to a meaningful Community Service, finding hobbies and interests that add to your life, and just enjoying the little things.

In no way do I want these comments to seem as though I am blaming the victims for their own unhappiness. I merely want to offer you some hope that active seeking to add some joy and excitement to your life may actually work and further reduce the oppressing depression. See the earlier discussion of [Happiness](#). Perhaps, once the hopeless lethargy has lifted, joy-seeking efforts should become a regular part of one's conscious efforts to defeat the remaining depression.

Level III: Skills (see chapter 13)

For most of us, sadness is associated with increased isolation--we just don't feel like socializing--and with more anxiety when we do interact. However, some depressed and socially insecure people become social addicts, even sexual addiction is not unknown (Scarf, 1980). Since our social-emotional reaction during a downer varies so greatly, obviously different social skills are needed by different people. After assessing your social strengths and weaknesses, use your assets and reduce your liabilities by gaining new social skills. Which ones? Several are mentioned below.

In spite of massive social skills training research, relatively little has been done in this area with depressed persons (except for Peter Lewinsohn's work). Intuitively, social skills ought to certainly help with loneliness, low self-regard, and boredom. Communication skills (e.g. "I" statements and empathy responses), relationship contracts, greater tolerance, and counseling should also help with relationship problems.

Social skills training

Social skills training improves your talents at meeting people, conversing, telling stories, selecting a friend or partner, and having a good time. Social skills don't come naturally to everybody; many of us have to learn and practice good communication skills, often involving close observation of others, role-playing, and other methods. Research has shown that having good social support is beneficial if you are depressed and it helps prevent depression in the future (Bennett & Bates, 1995). So, how do you get more social support? By acquiring more social skills.

Depressed people may not talk much *or* talk too much about their problems. Neither makes friends. After about 5 minutes, the self-put downs, pessimism, dependency, and whiny helplessness of talkative depressed people becomes unpleasant to most people. Yet, most depressed people long for meaningful contact; therefore, they must learn to interact differently. So, give the potential friend "equal time" and be an empathic listener during his/her time. Let the friend know you are down but suggest doing some fun things together too. Do things for others. A friend is different from a therapist--he/she has to benefit from the interaction too. Practice making light conversation; use your sense of humor.

Assertiveness training

Assertiveness training has had mixed success with depressives (Biglan & Dow, 1981). The interpersonal skills should add to self-confidence and encourage standing up for one's rights, instead of being submissive. Assertiveness is not fighting; it includes disclosing and expressing emotions, like personal needs and positive feelings, and should deepen relationships. Don't prematurely over-disclose; don't become self-centered or pushy.

Empathy response training

Empathy response training is quite effective in deepening and improving relationships. Use empathy statements for helping someone else. Make "I feel..." statements to help yourself express your problems and concerns to another person who is, hopefully, a good empathizer.

Communication

Training in marital communication skills, fair fighting, conflict resolution, and self-disclosure could greatly improve relationships. Intimacy and closeness, i.e. continued sharing of personal history, opinions, feelings, and dreams, could do wonders for one's attitude about life.

Decision-making

Decision-making and time management training may relieve depression, if one has neglected and made poor decisions or mismanaged his/her time. A series of mistakes can cause disappointment and a low self-concept.

Level IV: Cognitive Methods (chapter 14)

Build a more positive self-concept. More and more evidence is accumulating that positive self-esteem is an antidote to depression. Examples of helpful action: make more positive self-evaluations by noting your successes, abilities, good morals, traits, and actions (Homme, 1965; Vasta, 1976). This is especially important for the depressed people who have a severe internal critic. You must challenge and silence your unreasonable critic. Also, personal pride comes from believing that your successes are due to skills and discipline you developed and utilized to meet a challenge. Being successful because you inherited wealth or a good brain doesn't build the ego as much as "coming up the hard way."

If a person grew up in a non-rewarding, inattentive family, he/she may feel like an underdog and have little self-respect. Such people frequently drift towards "a bad crowd" and become antisocial because they gain some self-esteem in that way (Kleinke, 1991). They will probably need more than a shot of self-administered esteem-building cognition; they may need new social skills, educational-career-life plans, and a different peer environment. It takes courage to leave friends, especially if they are, for the moment, our only support system.

See method #1 in chapter 14 for an extensive discussion of building self-esteem. It is very important. Evidence suggests that self-esteem buffers us from the onslaught of anxiety, guilt, depression, shame, criticism and other internal or external attacks.

Challenge faulty perceptions, irrational ideas, automatic ideas, faulty conclusions, and excessive guilt. If your "automatic negative thoughts" slip by too quickly for you to notice (but they still cause sadness), try starting your search for the negative thoughts at the moment the emotions occur. Ask yourself, "What was I thinking when I got upset?" Or, "What was my view of the situation when I started to feel depressed?" These questions and the answers may help you uncover the well hidden self-blaming antecedent thoughts or interpretations of the situation. Write down your thoughts, and then objectively ask:

- What is the evidence for this idea (that may be causing me to feel bad)? Is it true?
- Is there another way of looking at the situation?
- Even if my first thought were correct, is it really as awful as I feel it is (or is the situation just "lawful" reality)?

Examples.

Feeling	Unreasonable thought	Reasonable thought
Self-critical	I can't do anything right.	I messed this up, but I can do better.
I'm rotten	If they knew me, they'd hate me.	I'm not all bad; they'd see that.
I'm odd & ugly	I'm so tall, I'm a freak.	There are real advantages to being tall.
I'm lacking...	I hate being so flat-chested.	I'm a beautiful & good person, so forget it.
I look old	My bald head looks awful.	My brain and personality will hide my baldness.
I'm stupid	I'm a terrible speller, I'm ashamed.	I can't spell but I'm a hell of a mechanic.

These methods, primarily from Beck and Ellis, involve detecting very primitive thoughts, checking their accuracy and replacing the harmful, inaccurate ideas with rational thinking (often based on observations of what really happens around us). Here are some more specific examples of methods:

Tolerance training (challenging your irrational demands). Learn that you don't have to get what you want and that you can't always avoid unwanted outcomes. Challenge the "tyranny of the shoulds" or the "musts." Examples: "Everybody should like me" (that's impossible!). "I must have a lover" (learn to enjoy being alone for a while). "They shouldn't lie to me" (they have their problems). There are reasons for everything; learn them and accept reality. This is discussed more in cause #6 above and in methods #3 & #4 in chapter 14.



"Whether or not it is clear to you, the world is unfolding as it should."
-Desiderata



Challenge false conclusions. The depressed person has been preprogrammed to think negatively and irrationally. This is not a conscious, intentional effort to come to negative conclusions; it is an automatic process. You just assume your negative thinking is right because you have always thought that way and no one has challenged your thinking. Now, you have to be your own challenger:

False conclusions

I forgot the assignment, I'm irresponsible.

(self-blaming)

John snubbed me, nobody likes me.

(over-generalization)

It's terrible if I can't be an MD.

(absolutism)

I'm a nerd, always will be.

I failed once, I'll always fail.

(irreversibility)

The teacher is mad because I

forgot

to do the paper. (personalization)

After my accident, they'll never

trust me.

(over reaction)

More reasonable idea

A mistake, I'll not do that again.

I'd better talk to John; others like me because I'm so good to them.

What a downer. What is my next choice?

I need some better social skills.

I'll learn and practice more next time.

Half the class is doing poorly, not just me.

One mistake doesn't destroy trust.

If some relatively minor event (not like death or divorce) has gotten us down--and we have stayed down too long--we must examine our conclusions about that event. Remember that depressed people demand too much sometimes, get obsessed with a loss, blame themselves (no benefit of the doubt), let events get them down, and don't think they can do anything about the depression. That is the nature of depression and low self-esteem. They see no silver lining, no light at the end of the tunnel, no opportunity for growth in this crisis. They aren't thinking rationally (see cause #7 above).

Avoid assuming responsibility for bad events and feeling guilt on and on. Recognize that it is unreasonable to assume that you are responsible for just the bad things in your life and not the good. Try to reduce your focus on your faults that may or may not have caused some loss in the past; instead, focus on your strengths that could improve your future. Likewise, guard against dwelling on and re-living the bad events and overlooking the good. Refer to #4 above. Flanigan (1996) offers advice about putting the past behind us and find self-forgiveness.

Unlike Seligman's dogs, challenge your assumptions that you are helpless. Acquire *Learned Optimism* and the courage to "give it a try," and you are on your way to success, more friends, less depression, and better health (Seligman, 1991). In all the specific actions for coping with depression, optimism is important: to some degree, the effectiveness of all anti-depression methods is a function of how much the user believes in the methods (Kirsch, Mearns, & Catanzaro, 1990).



An optimist sees opportunity in every calamity; a pessimist sees calamity in every opportunity.

I am the master of my fate. I am the captain of my soul.
-William Henley



Are optimists born? Maybe (watch a 1-year-old trying to walk). Certainly optimistic parents are a fortunate beginning, but even with pessimistic parents there is hope... (an optimist sees how change is possible). Until we are about 8 years old, we tend to be optimists. By mid-adolescence our thinking style is either optimistic or pessimistic and it tends to stay that way for the rest of our lives, unless we are persuaded or choose to change. Hope and self-direction are critically important factors in the outcome of human lives. Please pay attention if you are a pessimist. It's hard to become an optimist, requiring careful attention to every thought. The keys seem to be learning that (1) *every failure is an opportunity to learn*, (2) *we can change*, and (3) *success depends on effort*.

If you do any of the following: set your goals too low (nurse's aide instead of MD), expect to fail or to be disliked, feel things aren't ever going to go well for you, believe you just don't have the ability or the personality needed to succeed, or have other pessimistic thoughts, then you need "learned optimism." How can you get rid of the negative, defeatist ideas? Well, you might be able to just ignore the pessimism. But if you have brainwashed yourself well, then you will have to question the validity of your pessimistic ideas. Most self-putdowns are wrong, especially in the sense that most people could accomplish a lot more than they do--they sell themselves short. So, attack those self-destructive thoughts by deciding to think clearly and objectively, like a wise adult, about your feelings.

Look carefully at the typical pessimistic message: everything is terrible, always will be, and I'm to blame. This is close to Murphy's Law: Whatever can go wrong will. This is harmful, depressing crap you are feeding yourself! Recognize that these thoughts are a "left over" from an earlier time when things were going badly or someone was stuffing you with pessimistic thinking. Times have changed; the situation is different; you can be different. Rather than "nothing works out for me," how about "I'll try something new today." Rather than "he didn't want to play tennis with me--no one really likes me," how about "maybe he was busy," "maybe he isn't very good at tennis," or "I'll bet he'd like to do a lot of other things with me." For optimism it is important to have self-esteem and self-efficacy--faith in your ability to change things based on past experience (methods #1, #4 & #9 in chapter 14).

You Too Can Learn To Be Optimistic

Pessimism provides an important explanation of depression and learned optimism provides a means of recovery from hopelessness and depression. In fact, being optimistic has many advantages. A recent book chapter written by Shatte, Reivich, Gillham & Seligman (1999) describes an experimental depression prevention program for children (Penn Optimism Program or POP). Depression and feeling helpless, in part, comes from using certain learned ways of explaining things. Example: a depressed child tends to blame him/herself for things going wrong ("I'm so dumb") and sees the cause--his/her dumbness--as stable and influencing almost everything ("I mess up all the time and always will"). Even though still self-blaming, the child who says, "I did poorly because I didn't study enough," is much more optimistic because a change is possible--a solution is available. An optimistic child often thinks troubles are caused by external factors which are changeable or avoidable and have limited influence, i.e. "I can avoid this minor problem." Not uncommonly, the explanations may involve external but untrue causes ("The teacher has it in for me" or "He meant to hit me") and need to be changed to more self-responsible thoughts ("I'd get better grades if I studied" or "Maybe I bumped him."). To start thinking more optimistically and accurately requires careful attention to and explicit instructions (from trainers or yourself) concerning the details of one's thoughts and reasoning. No easy educational/therapeutic/self-help task.

In 12 weeks, the POP 2-hour groups of 10 to 12 depression at-risk children were taught (a manualized curriculum) to recognize how their interpretations of the causes of problems lead to their feeling depressed or optimistic, helpless, angry and so on. Then each child was given "retribution training," i.e. they were taught to use an optimistic "explanatory style" rather than a pessimistic line of reasoning (see Cognitive and Rational-Emotional methods). In this program, the POP staff taught children to think of many alternative explanations--both optimistic and pessimistic--of behaviors and, then, to decide which causes are the more accurate explanations, asking others for feedback in the process. The training demonstrated that pessimism leads directly to "catastrophic thinking" about the future. To counter this, the POP children were asked to write out their predictions of the future ("I'm sad because my Dad will probably leave") and then check how realistic those expectations really are (How often do other parents fight? Does that mean they will divorce? If divorced, does that mean you wouldn't see Dad? Are some kids happier after divorce?). The children come to see that optimism is a necessary part of problem-solving too, because in order to find a solution one has to consider the more relevant, more useable, more powerful ways of influencing the problem situation. So, the POP program also trained children to identify the best ways of changing or accepting bad situations... that's realistic optimism.

In conjunction with or in addition to more optimistic retribution training, the 5th and 6th graders in POP were taught several cognitive

skills: assertiveness, negotiation, relaxation, anger and sadness control, how to deal with procrastination, social skills, and decision-making. The results were impressive. As intended, the 12-week treatment program resulted in more optimism when compared to a control group. More importantly, only twelve percent (12%) of the at-risk children in the treatment program had suffered moderate to severe depression by the end of the 24 month follow-up period. However, thirty-eight percent (38%) of the untreated matched control group had suffered depression. Apparently, teaching cognitive methods for increasing optimism and accuracy in thinking as well as a variety of other coping skills helps prevent depression. If a 12 week, 2-hour-a-week psychology class can reduce childhood depression in at-risk children by half or 2/3rds, surely the world needs to pay attention.

Whenever you have a self-defeating pessimistic thought, ask yourself these five questions: (1) *Is it really true that you are helpless in this situation?* How certain can you be that something unavoidable and awful is going to happen? Are you sure you couldn't get an A in math? Why couldn't you build your own house? What are the real chances of a catastrophe? (2) *Is there another way to explain this event?* Did he/she leave me for other reasons rather than my being boring? Find as many possible reasons as you can. (3) *So what, even if it is partly true? Must it last forever? Must it mess up everything?* Suppose he/she did think you were a little boring, there is a lot more to it than that. Besides, it won't be hard to become more interesting to someone else. (4) *Is this pessimistic idea doing me harm right now?* If so, put it aside. Of course, you must not hastily dismiss every pessimistic idea: it is wise to heed your negative feelings about many things, such as driving while drunk, getting into a fight, burning down your house for insurance, etc. In short, simply insist that the negative idea be rational and useful before it shuts down your life. (5) *What is the best possible outcome I can hope for in this situation?* Logically, what do I need to do to turn this crisis into an opportunity? Question the rational basis for your guilt (see guilt section above and method #4 in chapter 14).



Optimists, who try the hardest, believe *success depends on effort*, not on innate ability or luck or social class or looks. So, work harder and become an optimist. Be responsible and become proud.



Attribution retraining

The depressed person is prone to believe "this bad situation will never get better," "it will ruin my whole life," and "it's all my fault." If

those views of the situation were accurate, the person has a right to be depressed. However, these pessimistic views are never accurate.

Changing your explanation of the situation can change your emotional reactions, obviously. If you shift your attributions so that you see yourself as less responsible for an unfortunate happening (divorce, failure, accident, thoughtless inconsiderate act), you should feel less guilty or depressed. If you change your attributions so that there is more hope of improving the situation in the future, even though you are held more responsible for the unwanted situation, you should feel less hopeless and more self-confident. For example, deciding "I'm going to have to work harder to succeed" is self-blaming for past failures, but it may be an accurate and hopeful assessment of the situation because you *can* work harder.

Likewise, starting to see an unpleasant situation as being caused by temporary or easily changed causes is hopeful (as compared with unchangeable causes). Example: "My grades were low because I had the flu... (or) I tried to study in the living room where there is TV, stereo, and lots of activity." Also, if the cause of an unwanted situation influences very few other things (vs. a cause that disrupts almost everything), that is a happier situation. Example: being six foot seven inches tall may only keep you from being a fighter pilot but a bad temper may destroy many jobs and relationships. Finally, depressed people use several attributions that may at first seem unchangeable (low ability, bad luck, they're against me), but these causes can be seen as modifiable (learn skills, change luck, avoid or disarm enemies). There are so many ways to make changes; we should almost never feel powerless.

For practice at changing your attributions (these are old thought patterns that don't change easily), try listing your weekly successes and explain them in terms of *your personal traits and skills* that are rather permanent and potentially useful in several areas of your life. This also keeps you from dwelling on your failures. Example: "My grades in math and social science went up because I learned to get myself organized every day, to enjoy studying these topics, and to use the SQRRR study method." (See #4 above)

Successful self-help projects build confidence in your ability to make your world better (see self-efficacy in chapter 14). Sounds simple but much is involved: you must select some meaningful life goals, then acquire knowledge, skills, and role models so you can achieve these goals, and finally exert considerable effort so the achievement of the goals creates pride. Just saying "I can help myself" is not nearly as impactful as actually changing yourself (sort of like saying "I care for starving kids" and doing nothing versus saying "I care" and actually taking a hungry child on your lap and feeding him/her).

Consider failure to be a sign you need to work harder or need more practice, rather than proof you are "a failure." Moreover,

wise people have advised "learn from your mistakes" and "make mistakes--lots of mistakes--just don't make the same mistake twice." If we can take that attitude, i.e. "I'm just learning to master this situation," we could be much more tolerant of our failures. We don't have to succeed. Many great people have only made it by having the courage to face repeated failure: Lincoln, Van Gogh, Frank Lloyd Wright, Gertrude Stein...

Watch for and change your overly negative, unquestioned, self-blaming thoughts. Example: "I got a 'C' because I'm stupid" (no, because I didn't study enough or have good study methods. I can't judge my ability to do school work until I put my best efforts to an extensive and fair test).

Observe the relationship between your thoughts and mood; prove that "illogical thoughts cause my depression, not my stupidity, looks, or badness...and I *can* change those damned thoughts." Also note expectations and outcome: if you expect little or nothing of yourself, you'll probably do poorly. If you expect to do impossibly well, you'll certainly fail. Your ambitions need to be challenging but realistic.

Guard against self-handicapping (discussed in chapter 4). This is where you claim to have a handicap, perhaps "I'm sick," "I was up all night," "I have test phobia," "I didn't prepare," "I'm nervous and shy," "I've had a bad experience," "I'm on medication," etc. These handicaps are designed to excuse a poor performance (if that is the outcome); thus, prepared-in-advance handicaps reduce our motivation to do well. It is true that no one will be able to tell how able or disabled we are as long as there is no accurate test of our ability. That's the real pay off. But there are costs: we never get to know ourselves, we are likely to feel inadequate (*we* know we haven't tried), and we get little pride from always being handicapped.

Guidance. If you have no purpose, if you are bored, if you feel worthless or guilty or irresponsible, you need a guiding, inspiring philosophy of life. See chapter 3 quick. A meaningful life needs to have a purpose that firmly guides what you do every day. Life's purpose doesn't have to be grandiose or religious, but it should increase the good in the world and reduce the bad; it should make you proud. Self-esteem and self-efficacy also involve wanting to learn, mastering challenges, and developing skills and competencies. Your 2 1/2 pound brain is a fantastic organ. Don't waste it.

Lowering your aspirations. Disappointments could be reduced by lowering your aspirations and/or just accepting reality ("that's just the way the ball bounced"). See 29b. Guard against frequent obsessions with personal faults, such as being only average in intelligence, being small and skinny, being tall, being "ordinary" looking, having ugly ears, being shy, not catching jokes, and so on. Many of these worries are not correctable or don't really matter; other worries can be changed, but they aren't solved by just feeling depressed about the problem.

Determinism or humanism. A deterministic view of how the world operates can make one more tolerant of oneself, more accepting of others, and more hopeful of the future (method #4 in chapter 14). Self-acceptance may also come from a humanistic viewpoint in which each person is intrinsically respected, valued, and loved. Each human is different and makes an important unique contribution to the world (Jampolsky, 1979; Buscaglia, 1972).

Religion. Finding comfort in a religion and acceptance in support groups has helped many people overcome depression. Every community has several religious communities. There are many self-help groups (or you can start one). There are also televangelists, many religious writers, and spiritually oriented psychologists, such as Jampolsky (1985) and Peck (1993). See the discussion of self-help groups in chapter 5 and religion in chapter 14.

Look to the future. Sometimes the heavy weight of today's burden is lightened by asking: What will life be like next month? in six months? in a year? in five years? in ten years? All things change. Given a more distant perspective, there may be less gloom and more hope.

Talk yourself up. As with anger, we can learn to interpose positive thoughts or self-instructions between the disturbing event and our emotional reaction so that the sadness is reduced. For instance, as discussed in chapter 14, suppose you have just been told by your boy/girlfriend that they want to terminate the relationship. How can you reduce the pain and depression? The pain can't be avoided but it may be dulled and shortened a little. Look for positive aspects: "At least a decision has been made" and "It's good that I found out now about her/his being unsatisfied, rather than after we were married." Look for your good points: "I'm proud of how I handled the relationship" and "I didn't try to just be what he/she wanted; I want someone to love the real me." Look for support from others: "All my friends will support me; some didn't think he/she was a good choice for me any way." Look for a positive future: "I will be a better companion in the future and I know a lot more about what I want in a relationship."

What seems nasty, painful, or evil, can become a source of beauty, joy and strength, if faced with an open mind. Every moment is a golden one for him/her who has the vision to recognize it as such.

-Henry Miller

If a loss can be anticipated (like a death), realistically facing the situation, discussing it with others, and emotionally "working through"

the loss can reduce the impact. Also, if the loss can be seen as less personal ("it's not my fault") and less catastrophic, it should be less depressing and you will probably have a quicker recovery.

Note: obviously some of the behavioral and emotional suggestions given above are partly cognitive in nature too.

Level V: Unconscious factors (chapter 15)

When you read the case histories of many depressed people, it seems unlikely that the above methods will cure the enormous misery they suffer. This is especially true of cases with abusive childhoods as described by therapists cited in the section on shame or by Susan Forward in *Toxic Parents* or Arthur Janov in *The New Primal Scream*. They all contend that it takes years to overcome the feeling that you are unwanted, worthless, disgusting and so on. It is my experience that some depressed people are helped with the behavioral-cognitive-skills methods, particularly those struggling with losses and mild depression. But those who were miserable as children, always feeling alone and shame-filled, never liking themselves nor truly trusting others, and remain profoundly unhappy, they are difficult to treat. It doesn't seem likely that some simple advice, like "think positive," is going to cure them (but it might help).

Although Freud would say, "I told you so 100 years ago," there have been several recent cases in which early childhood experiences of trauma and abuse have suddenly popped into consciousness. These insights are sometimes reported to be relieving--like a load is lifted. I believe some people do need to unload their emotional burdens, their "unfinished business." But, I don't believe every sad person was abused as a child. It is impossible, given our knowledge today, to know the true and original "cause" of a person's depression. I say this because the cause given for your depression depends on what therapist you see, i.e. most psychiatrists would say "chemical imbalance," Beck and Ellis would say "faulty thinking," Seligman would say "helplessness and pessimism," Bradshaw would say, "shame," etc. It is strange that each theorist only sees *his* kind of depression. We haven't put the elephant together yet.

Certainly, some traits related to depression, especially to shame, go back to the first few years of life. Indeed, many depressing attitudes have a long history: feeling inferior, helplessness, pessimism, guilt, self-criticalness, perfectionism, hypersensitiveness, shyness, dependency, socially neediness, hostility, and being without systematic values to guide our lives. Naturally, theorists are prone to blame parents for the weaknesses starting in childhood. We should keep in mind however that just as the guilty, sad, self-critical, shame-filled person may have learned those things in childhood, the angry, degrading, neglectful parent developed his/her basic personality as a

child too. You can't point the finger of blame at just one person; it's more complex than that.

If you could learn to understand the development of any of the just mentioned factors or if you became more aware of how these feelings show themselves in subtle ways, you might be in a better position to reduce their impact on your life. Example: suppose you grew up feeling that you were slighted by your parents and concluded it was because you did not deserve to be dealt with fairly and as a worthy person. If you understood the origin and irrationality of this low self-concept, you might stop your self-put-downs, start seeing your strengths, and begin to tactfully demand your rights with others, i.e. stop responding with self-put downs like you did as a 10-year-old. Here are some "insight" methods:

Read some insight-oriented psychological writings about depression, then self-explore and try to figure out your own dynamics. Assume the responsibility for getting insight into your life. Check your ideas out in a support group. You may have a thoughtful friend, if you are very lucky, with whom you can discuss the causes of your depression, but often you are on your own to "analyze" your psyche. I have already cited references in the specific areas of depression. General insight books include: Bass and Davis (1988), Miller (1983), Schaef (1989), and Forward (1989).



Warning: Some writers (especially Bass & Davis, 1988) declare that *repressed* childhood traumas, such as sexual abuse, are the probable cause of specific adult problems. It is true that abuse can be repressed (forgotten). And, since remembered abuse is sometimes (not always!) associated with adult problems, it is quite possible that repressed abuse could cause long-term problems. *But* no therapist or book can or should state that *you* probably have been abused just because you have certain symptoms (assuming you have no memories or other evidence of abuse). On the other hand, *false* memories of abuse are sometimes developed. When this happens, false accusations of childhood abuse can cause great distress to others (and might the victim's depression worse). This is discussed in greater length in chapter 15.



Unconsciously motivated interactions. Read in chapter 9 about "games people play" according to Transactional Analysis. These are unconsciously motivated interactions with others in which we may goof up and/or get put-down, thus confirming our childhood beliefs that we are inferior and undeserving. Once we know that we are designing our own failures (and for "sick" reasons stemming from early childhood), we can use our Adult intelligence to stop these self-defeating games.

Anger and guilt. Depression is often associated with, maybe even concealed by, other emotions, especially anger and guilt. Research reveals that anger with the spouse is often the true source of depression. Therefore, the other emotions may have to be dealt with before the sadness shows itself clearly. Then the depression can be deconditioned, attacked cognitively, or understood through insight. Remember, our guilt may be unjustified (see section above) and our anger is likely to be suppressed (see next chapter). Flanigan (1996) writes about forgiving yourself. Often we are very angry about how we have been treated, but we have been taught that it isn't nice to be hostile (and besides it may actually be dangerous), so we don't talk about it. Venting might help. Determinism, too.

Shame. In some cases, for instance with shame, it may be necessary to uncover the original early childhood pain that made us feel inadequate. Then you can nurture the hurt, fragile inner child and build your self-esteem using more rational and mature methods. Several ways of reducing shame are described in the special section on shame above. Be sure to see John Bradshaw's books.

Our inner child. Chopich and Paul (1993) describe how our "inner child" may be abandoned and shamed by our own "inner adult." When this happens the inner child feels very negative about itself, including feeling bad, shame, fearful, and in need of addictions to numb the hurts. Their treatment (it could be self-help) involves encouraging our adult part to attend to, accept, protect, and take care of our inner child. A healthy, protected inner child is very valuable to us; it is intuitive, creative, passionate, full of wonder, playful, energized, sensitive, wise, and fun. Basically, self-help of an insight nature for depression involves getting to know our true feelings, i.e. understanding and accepting our self, including our inner child. Self-esteem results, in part, from our inner adult loving our inner child. Again, see the discussion of shame in the previous section.

The best treatment

I'll end this long chapter with a description of ideal treatment. It is expensive unless you have good health insurance. It is certainly extensive and hard work. One of the more highly recommended (particularly by insight therapists) self-help books for depression is by a psychologist, Richard O'Connor, *Undoing Depression*, (1999). In essence his book recommends getting an insight therapist and then supplementing that therapy with careful self-observations that help the depressed person understand how and why they are different and depressed. In conjunction with the insight therapist, the patient can observe how he or she sees the world; how he or she doubts that he/she can ever change and meet their own standards; how he/she feels towards and interacts with others; how he/she sees more criticism and hostility directed toward him/her than others do; how he/she is puzzled by human emotions, and so on. These are not easy feelings to uncover and they tap into both the scarier feelings and the stronger needs of a depressed person.

Depressed people are often needy, steadily seeking some accomplishments to make them feel good. They may be strongly dependent on others for encouragement and support. Self psychology theory, founded by Heinz Kohut (1971), called such a supportive relationship a “self-object.” The depressed person especially needs others to feel positive about him/her. As a child, the depressed person needed to idealize his/her parents and, in turn, have them offer ample support and affection, otherwise he/she feels alone and vulnerable. The young child wants to feel clearly and openly loved, powerful and adored. If this doesn’t happen with the parents, the child and later the adult constantly look to others for affirmation.

According to Kohut and O’Connor, depression is a result of suppression or loss or denial of the parts of the self that contain deep hurts. A depressed person uses [several defense mechanisms](http://psychologicalselfhelp.org/Chapter5/chap5_60.html) (http://psychologicalselfhelp.org/Chapter5/chap5_60.html) that help us hide the painful childhood memories and feelings. O’Connor calls these defenses the “skills of depression.” The problem is: the pain, hidden by the defenses to protect us, continues to cause the misery of depression but the repression keeps us from being aware of the sources of our depression. And just as Freud said, insight therapists believe these suppressed, hurtful feelings, like being unloved as a child, have to be uncovered, re-possessed, looked at again and worked through as an adult to overcome the pains of childhood. With defense mechanisms at work, the depressed person would probably make use of various other symptoms produced by the defenses, such as denial, excuses, distortions of reality, and focus on other problems to hide the real hurts and fears. Since the defenses hide our needs for love and security, we devise other indirect ways of asking for care and concern, e.g. complaining about feeling tired, having aches and pains, or complaining about other people, arguing, and getting in trouble or just plain withdrawing.

O’Connor makes the point that depressed people do depression very well—the defenses against past hurts get rid of the upsetting memories. So, he says what needs to be done is to undo depression...to undo the defenses and deal with the pain instead of denying it so we can learn to experience all the emotions life brings—pain and hurt as well as joy and excitement. Undoing depression requires new skills. Most depressives feel guilt and a sense of failure. They are often perfectionists. They feel responsible for bad happenings. Their self-esteem is probably low. Feeling unlovable they may be lonely. It is natural to try to put bad feelings out of mind. Changing this tendency requires new viewpoints and a different way of thinking.

Getting better—in therapy or by oneself—involves past hurts and one’s own guilt. For example, you may have felt intense anger towards someone and the defenses have helped you put that episode behind you, but the guilt about the anger may still be there in full force. The anger and the guilt need to be dug up and understood in terms of why you did what you did and in light of the current situation. Keeping a daily mood journal may help you uncover underlying feelings, assess the appropriateness of your emotions, see the history and causes of your irrational emotions, understand the role of your defense mechanisms in prolonging your depression, etc. Antidepressants may reduce the depressed person’s sad feelings but they can still lack confidence, be shy, lack social skills, feel guilt and shame, avoid hard tasks, be faced with an unhappy marriage or work situation. New skills taught by a therapist or

learned through self-help education are needed. There is never—well, rarely—a single cause for depression; the person him/herself and the therapist have to look for hurtful childhood experiences, upsetting current situations, and genetic-family traits.

The needed skills aren't just uncovering childhood hurts and anger. Learning ways to express one's feelings is very important and counter to the depressive's tendency to suppress feeling. Not having feelings is an unhealthy condition. Writing feelings in a journal may teach you how to better express feelings to yourself and with others. Learn to use several social/communication skills in chapter 13 that deal with handling emotions. If you are uptight, learn to relax. However, O'Connor makes a good point when he says some of "the skills we develop with depression in a vain effort to save ourselves pain—emotional over-control, isolation, putting others first, being over-responsible—prevent our recovery." So one has to look for traits and habits that stand in the way of tactfully expressing one's feelings and then develop ways to experience and share feelings.

Since so much depression occurs unconsciously, it is reasonable to seek professional help with this problem. This doesn't mean you are hopeless without an insight oriented therapist. What I hope I have made clear is that mastering self-help techniques can increase the efficacy of psychotherapy and improve the eventual outcome.

Conclusion: Final words of advice

Don't let your computer get overloaded looking at all these methods. Remember just reading will not make you happy; you must DO SOMETHING with the ideas you read! You must change how you act and think. Find two or three methods that seem practical to you and give them an earnest try! If your first attempts don't work, try something else until you feel less depressed.

Don't assume that the psychological methods above will instantly change or overcome the ways you have been acting, feeling, or thinking for many years. You can't just plan one active, fun weekend and, then, expect the depression to lift forever. You can't try stopping depressing thoughts for two or three hours and, then, expect these upsetting ideas to stop forever. You can't just try for an hour to think of positive things about yourself and, then, expect to like everything about yourself ever after. It is a major undertaking to change yourself from a pessimist into an optimist. We are talking attending to details for weeks or months.



Note again: If your depression is serious or dangerous, get professional help immediately. Even if your depression is not serious but a support group and/or your self-help efforts are not helping, get individual therapy from two experienced professionals--a MD and a psychotherapist. If medication has not helped, see a psychotherapist. If several sessions

of psychotherapy has not helped, get medication from an MD and consider getting another psychotherapist.



I must repeat that antidepressive medication and PMS treatment are important sources of help. Scientists don't know exactly how the drugs work, but for some people antidepressants are a godsend. Strangely, many studies have shown that 30%-40% of depressed people improve when given a sugar pill for the depression, while about 50%-65% improve on an antidepressant. We don't know why placebos are so powerful with briefer and milder depressions. But for deep depression (including weight loss, early morning awakening, continuous sluggishness, total loss of interest and pleasure in life) antidepressants are necessary and far more effective than a placebo (Brown, 1995).

About half of all people evaluated by a psychiatrist for any problem are prescribed drugs! Over half of patients ordered to take drugs by psychiatrists are told to take anti-depressive medication! And, *private* psychiatrists, the most expensive kind, prescribe about 70% of all anti-depressive drugs, not Mental Health Centers or family physicians or other *public* clinics (this may be changing as selected psychoactive drugs, such as Prozac, become popular and fashionable). As mentioned, the benefits of drugs can be life-saving for some people, so psychiatrists like Kramer (1993) strongly advocate Prozac for depression. Likewise, treatment for PMS helps many women avoid depression and tension.

Many depressed patients feel certain that their prescriptions are very beneficial. Yet, everyone shouldn't assume that drugs will be an easy, cheap panacea for them. Drug companies spend \$5 billion a year to promote drugs. Recent studies, however, using patient ratings and effective designs, have found that for many people antidepressive medication gave little relief from depression (Greenberg, Bornstein, Greenberg, & Fisher, 1992; Breggin and Breggin, 1994; and Fisher and Greenberg, 1995). Even psychiatrists admit that perhaps 30% of severely depressed patients are not "cured" by antidepressants. Nevertheless, the point is: millions of other people *have gained relief* by using prescribed drugs even though less than 20% of depressions have identifiable medical causes. Drugs should not be avoided, but the truth is that many people won't use drugs, and when they do, the drop out and relapse rates are higher with drugs than with psychotherapy. Effective drugs (which include placebos) should be used cautiously in conjunction with psychological methods (treatment and self-help).



A Special Caution: Many physicians prescribe antidepressants, especially Prozac, without recommending psychotherapy.



It is becoming common to prescribe Prozac (over 1 million prescriptions per month, mostly by non-psychiatrists). Because of the hype and few side effects, Prozac is considered a miracle cure for many things: eating disorders, obsessions, compulsions, shyness, unassertiveness, poor thinking, low productivity, weak personality, low zest, lack of confidence, lack of poise, etc. None of these "treatments" have been proven. Be careful when you take drugs. Prozac may be helpful with depression but its help with these other problems is questionable.

The effects of Prozac are enhanced by its popularity, i.e. a powerful placebo effect. In addition, Prozac seems to act as a stimulant, something like a mild amphetamine of the 1960's. These two factors lead many depressed patients to be convinced that their Prozac prescriptions are very beneficial, say the Breggins (1994). However, when drugs become a well advertised fad (like Valium a decade ago and Prozac recently), we "medicalize" our problems, i.e., we see our feelings as caused by uncontrollable biochemical factors permitting us to deny our history, our conflicts, losses, and stresses, and our morals or personal failings. Feeling better becomes the doctor's responsibility; we don't have to try to help ourselves.

Don't overlook the effectiveness of psychological treatment. Several extensive investigations conclude that psychological treatment, such as improving social skills, increasing pleasant activities, and correcting maladaptive negative thoughts, yields better long-term outcomes than drugs (Antonuccio, Danton, & DeNelsky, 1994). Both cognitive-behavioral and psychodynamic-interpersonal therapies work with depression (Gallagher-Thompson & Steffen, 1994; Shapiro, et al., 1994). So, don't think that psychology is just a cheap, second-rate source of help for depression; objective research says psychotherapy is the best treatment you can find but, like drugs, psychotherapy doesn't work for everybody.

Psychological methods aren't just for reducing depression; there is evidence that psychoeducational sessions can *prevent* depression. Gillham, Reivich, Jaycox & Seligman (1995) gave 5th and 6th graders 12 sessions covering some of the cognitive and social problem-solving skills mentioned above. Among those getting training, only about half as many (compared to an untreated control group) got depressed during a two year follow-up.

Don't forget there are many sources of self-help with depression, especially books. Some are excellent, especially both of

Burns's books (1980, 1989) which give detailed instructions for a cognitive psychology approach to reducing depression. Recently, a rare evaluation of a self-help book showed that *Feeling Good* reduced depression (Jamison & Scogin, 1995). Mental health workers also recommend Burns highly (Santrock, Minnett & Campbell, 1994). Research says cognitive methods are the best we have today. Also, among the better books for general psychological self-help with depression are: Carlson (1994), Lewinsohn, et al. (1986), Preston (1989), and Ellis (1988). One of the more extensive packages for depression and manic depression involves two books and a video tape by Mary Ellen Copeland (1993, 1994).

A man (Emery, 1988) and a woman (Braiker, 1988) have written cognitive therapy books for depressed women. A psychiatrist has addressed dysthymia, i.e. long lasting but moderate depression (Hirschfeld, 1991). Herskowitz (1988) gives advice to parents with a depressed child. Hipp (1996) writes for the teenager suffering through a loss--a death, a divorce and so on. For genetic factors in depression, see Arterburn (1993). Gold (1986) and Klein & Wender (1988) do a good job describing drug treatment before Prozac; Kramer (1993) tells you about Prozac but oversells it.

For coping with death, loneliness, perfectionism, low self-esteem, lack of hope and motivation, and boredom, see the sections above. For low self-esteem, see chapter 14.

For more information write for: *Depression: Awareness, Recognition, Treatment*, National Institute of Mental Health, Rockville, MD 20857 or phone 800-421-4211. The National Depressive and Manic Depressive Association, Box 3395, Merchandise Mart, Chicago, IL 60654 also provides information (phone: 800-826-3632). There is a Clearinghouse for Depression on the internet at <http://www.psycom.net/depression.central.html>. The Clearinghouse cites many references, including Mindstreet TM's *Cognitive Therapy* (8 hours of computer assisted psychotherapy) and Lewinsohn et al (1986) book which is available on line. For older persons, booklets (D14220 & D14862) are available from AARP Fullfillment (EE0713), P.O. Box 22796, Long Beach, CA 90801-5796. Also, a film is available (\$29.95) from Impact Resources, Murrieta, CA 92564-1169 or 1-800-333-6475. For depression oriented self-help groups, write Depressives Anonymous, 329 East 62nd St., New York, NY 10021 or phone 212-689-2600.

There are many Web sites on depression, check a search engine. I will just mention a couple of good URLs: [Mental Help Net-Depression](http://mentalhelp.net/poc/center_index.php/id/5) (http://mentalhelp.net/poc/center_index.php/id/5) , [Mental Help Net-Bipolar](http://mentalhelp.net/poc/center_index.php/id/4) (http://mentalhelp.net/poc/center_index.php/id/4) , and [Mental Health Recovery-Depression](http://www.mentalhealthrecovery.com/index.html) (<http://www.mentalhealthrecovery.com/index.html>), John Grohol's [Psych Central](http://psychcentral.com/resources/Depression/Articles/) in three places: (<http://psychcentral.com/resources/Depression/Articles/>), (<http://psychcentral.com/resources/Depression/Books/>), and

http://psychcentral.com/resources/Depression/Seasonal_Affective_Disorder/).

Special mention should be made about Postpartum Depression. Any woman who gets pregnant, has or loses a baby, or has weaned a baby recently can get this disorder. The risk is significantly higher, however, if the mother has been depressed and been treated before getting pregnant. The symptoms differ from person to person, some get sad and cry, some get tired and fatigued; some get very emotional and so on. The same person's mood may rapidly change, for example being sad early in the morning and feeling they just can't handle the situation by themselves today, by 10:00 they may be feeling OK, and then in an hour feel very angry with the husband or very tired and wanting to sleep. It is important to talk to your doctor about any kinds of feelings. It may not be clear what is causing these changes but many women benefit from talking to other mothers in a support group and finding out that it isn't unusual for a young woman have the similar reactions. It is treatable.

Kleiman (1994) has written a helpful book for women having postpartum depression or other emotional reactions. There are also very good Websites:

[Postpartum Depression](#)

(<http://www.4woman.gov/search/newsresults.cfm?criteria=Postpartum%20depression&searchtype=news>), [Postpartum Support International](#)

(<http://www.postpartum.net/>) and [Depression Central](#)

(<http://www.psycom.net/depression.central.html>) where you can search for information on postpartum depression.

[A Manual for the Bi-Polar Depression Phenomenon The Wave Riders Gift](#) Top Rated

"Bipolar depression has been increasing because our minds have been evolving. We have been given a gift of creativity and now we have the manual. The Wave Riders Book: how to have the life you have been seeking."
URL: <http://www.thewaveriders.com/>

[Beyond the Blues, A Guide to Understanding and Treating Prenatal and Postpartum Depression](#)

Most current and concise book on mood disorders in pregnancy and postpartum. Written for health practitioners and consumers.

URL: <http://www.beyondtheblues.com/>

[Feeling Good Handbook](#) Top Rated

by Dr. David Burns

Plume Publishers, Inc. (ISBN: 0452261740) The daily homework assignments coupled with the elaboration of the kinds of cognitive mistakes everyone makes everyday (for instance, overgeneralizing one bad thing which happens to you to mean that you are a bad person) are especially helpful. It is really chock full of useful and down-to-earth explanations and things which people can do everyday to try and help themselves. Based upon Aaron Beck's cognitive work in researching depression.

[Anti-Depressant Skills Workbook](#)

This free, 47-page self-help manual is a practical evidence-based guide to

applying cognitive-behavioral therapy strategies to recovery from depression. Developed by a mental health services research group at the University of B.C. in Vancouver.

URL: <http://www.carmha.ca/publications/?publication=asw>

[The Noonday Demon: An Atlas of Depression](#) Top Rated

The Noonday Demon's contribution to our understanding not only of mental illness but also of the human condition in general is stunning. The book examines depression in personal, cultural, and scientific terms. URL:

<http://www.noondaydemon.net>

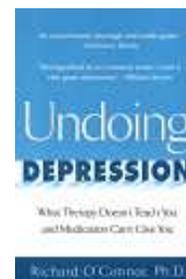
[Undoing Depression](#) Top Rated

Undoing Depression: What Therapy Doesn't Teach You and Medication Can't Give You

by Richard O'Connor

Richard O'Connor knows what he talks about in one of the most thorough, comprehensive, and enjoyable books I've ever read on the beast we call *depression*. URL:

(<http://www.undoingdepression.com/index.html>)



Bibliography

References cited in this chapter are listed in the [Bibliography](#) (see link on the book title page). Please note that references are on pages according to the first letter of the senior author's last name (see alphabetical links at the bottom of the main Bibliography page).

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