TOWN & COUNTRY'S GUIDE TO

DEALING WITH DEPRESSION

It affects 19 million Americans, two thirds of whom do not get help. Though the illness defies easy explanation or cure, today's treatments can give lasting relief.

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THE ELUSIVE AFFLICTION

BY N.F. SMITH

"I believe I first knew something was wrong when I was in the fourth grade. One day I got up from my desk, walked down the hallway to the bathroom and sat down on the floor behind the toilet. I just crouched there. I was trying to make sense of these powerful feelings. I remember thinking that I had to be sad for a reason, but I couldn't think of a reason."

Today, Tracy Thompson is both the mother of a three-year-old and an award-winning journalist with *The Washington Post*. For nearly thirty years, she has struggled with depression. And she is not alone in that dark territory. More than 19 million Americans—almost twice as many women as men—are afflicted with clinical depression. Some of them will die by their own hand. Depression costs more than $40 billion a year in lost wages and health-related expenses. The World Health Organization estimates that by the year 2020, depression will be second only to heart disease as the world's leading cause of death and disability.

And it is on the rise; experts have seen a marked increase since World War II. Some of the change is probably due to greater awareness and better diagnosis. But also, says Myrna M. Weissman, M.D., professor of psychiatry and epidemiology at Columbia University's College of Physicians and Surgeons in New York and author of the new book *Comprehensive Guide to Interpersonal Psychotherapy*, "The situations we know to elevate the risk of depression in vulnerable individuals are increasing. There are more divorces, people are moving around more, living alone; there's more stress."

Fortunately, the stigma of depression has lifted measurably in recent years. As Tracy Thompson says, "I went from believing that the *Post* would let me go if anyone discovered my secret to knowing I could write a book about it without jeopardizing my future." Her journey has taken her through an extraordinary period of change in how mental health is viewed, diagnosed and treated in the U.S. Because more is known about the brain and genetics and how the two interact with the environment to affect emotional well-being, new, more targeted treatments have been developed. Perhaps because of this progress in medical understanding, the subject of depression is less taboo. It may also be because people with these illnesses are coming out of the shadows. High-profile sufferers—among them Pulitzer Prize-winning writer William Styron, "60 Minutes" correspondent Mike Wallace, Tipper Gore, television journalist Deborah Norville, and actors Rod Steiger and Winona Ryder —have spoken publicly about their battles with the demons.

But that is not to say the public discourse concerning depression can ever be straightforward or clear. The topic is exceedingly complex and controversial, its concepts elusive. These days, the biochemical explanation of depression is widely and enthusiastically embraced. The solution, according to this view, lies primarily in a regimen of pills. But are our moods, emotions and thoughts really nothing more than the effects of chemicals mixing it up in our bodies? Even if they are, is medication the best or only way to tame those moods and emotions? Do we want to tame them? And given the fact that suicide is a very real and final "symptom" of depression, is it right to question the use of antidepressants?

Viewed through another lens, depression may be seen not so much as a chemical imbalance but as a complicated mystery woven of many influences in our lives, from the spiritual to the mundane. Is it our responsibility to unravel the mystery? Is it reasonable to think we can take control of our moods by shaping our lives differently?

CHARTING A NEW COURSE "We've begun to create new models for how we think about mental health," says Dr. Weissman. "By acknowledging that the mind can affect the body and that the environment, which we can influence, is acutely involved in physiological function, we've expanded the possibilities for treating—and preventing—many disorders." The new models assert that an event in one's life could cause changes in the structure of the brain, just as changes in the brain can cause disruptions in one's life. And they recognize that the symptoms of depression most likely spring from several sources.

This important shift in thinking has expanded the debate about depression. What was once, as Styron puts it in his book *Darkness Visible*, a "schism between the believers in psychotherapy and the adherents of pharmacology" has evolved into a multisided conversation about layers of causation and many facets of treatment, including medication and psychotherapy, as well as diet, exercise, spirituality, stress control and other lifestyle modifications.

Although Prozac and its fellow antidepressants have been catapulted to prominence in the treatment arena, there's growing interest among scientists in how events in the world—one's lifestyle and experience—might trigger the malady, and how a wider understanding of these factors might provide improved strategies for dealing with depression. "We accept these relationships between lifestyle and health when we think about hypertension," says Frederick K. Goodwin, M.D., director of the Center for Neuroscience, Medical Progress and Society at George Washington University Medical

Center and past director of the National Institute of Mental Health. "Severe hypertension needs medication; milder forms can be handled by diet, exercise and stress reduction. Why not depression?"

Depression may be nature's way of letting us know that something's gone awry in our lives and that it's time for a change, according to Randolph M. Nesse, M.D., director of the Evolution and Human Adaptation Program at the University of Michigan's Institute for Social Research. As a natural adaptation that makes you slow down and reflect, depression can be viewed as a mechanism that keeps you from persisting too long in a behavior or activity that has grown increasingly unproductive or unhealthy—a bad marriage, perhaps, or an unfulfilling career, even poor nutrition or sleeping habits. "You can't really fix the depression until you learn new, healthier ways of dealing with the problems in your life," says Ralph Carl Mumpower, a psychologist in Asheville, North Carolina.

DEPRESSION'S GRIP Depression is the most common of psychiatric illnesses, affecting about 10 percent of all Americans in a given year. Researchers don't know for sure why life events cause depression in some and not in others. It has been established that, for many sufferers, genetic predisposition plays a part. Interestingly, however, not all genetically predisposed individuals do get depressed.

"We confuse depression with the blues," says Scott E. Ewing, M.D., director of the Depression and Anxiety Disorder Service at McLean Hospital in Belmont, Massachusetts. "We've all suffered from sadness and despair. We tend to think if *we* got better, the next person can too." The confusion persists in large part because of the very nature of the symptoms of depression. The patient must try to explain why he is unable to get out of bed, can't concentrate, is plagued by feelings of worthlessness. Blood tests and tissue cultures cannot reveal the source of pain.

Paul Gottlieb, publisher and editor in chief of Harry N. Abrams, Inc., the prestigious art-book publishing company in New York, tells of gradually coming to realize that his "everyday feelings" were something more. "When my symptoms began I was just turning 40, and I thought, 'Ah, this is my midlife crisis,'" he says. "It kept getting worse. Night after night, I'd lie in bed, sleepless. When morning finally came, it would be a major effort to turn the covers back and get up. It's as if the walls were coming in at me. Instead of engaging with people or circumstances, I was drawn completely inward. I was terrified people would find out that I was a shell. I spent tremendous effort controlling my behavior, controlling my reactions. Toward the end, suicidal thoughts came daily. This went on for six years, until I was sure I would follow through with the suicide—that's when I finally got the help I needed. Ten days after I started taking medication, I was better. It was miraculous. Since then I have not suffered what I consider the illness of depression."

HOW TO KNOW Anyone who experiences the sadness brought on by the death of a loved one, or the anxiety generated by a stressful job, might know depression, at least for a time. But what does it mean to be clinically depressed? Is the difference between simple sadness and deep depression one of degree? The distinction, medical experts say, lies in the duration and severity of the symptoms. "If your blue mood doesn't interfere with your life, and if it lasts for only a couple of weeks, then you are sad, or mildly depressed," Dr. Scott Ewing explains. "If it devastates your life and goes on for weeks without abatement, you should seek treatment."

The official definition of the different kinds of depressive disorders can be found in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, the bible of psychiatric diagnosis. The symptoms of major depression usually appear sporadically, in what are called depressive episodes; they affect all parts of the patient's life—physical, emotional, mental—and persist for weeks at a time. The illness ranges in form from relatively moderate to severe, the latter marked by complete mental incapacitation, including auditory and visual hallucinations and delusions.The symptoms of depression in its mildest form can lead to a diagnosis of dysthymia, a chronic

condition in which the patient is always slightly depressed.

Several types of depression are associated with discrete events. Postpartum depression follows the birth of a child; Seasonal Affective Disorder (SAD) is related to the shorter daylight of winter; and premenstrual depression affects women just prior to and during their periods. "We don't know what the mechanism is that underlies these episodes," says Michael Cochran, M.D., a psychiatrist on the clinical faculty at Stanford University Hospital, "but they are very real. The symptoms are the same as any case of major depression."

THE ROAD TO WELLNESS Current research indicates that more than 80 percent of depressed patients will respond to treatment, yet the National Institute of Mental Health says that nearly two thirds won't get help. Why? The lethargy that is a symptom of depression can keep people from seeking help; so can the social stigma or even a lack of understanding of the disease. And since severe depression is an episodic illness, the sufferer often just waits it out. Finally, with the recent changes in the healthcare system, more and more mental illnesses are first diagnosed and treated by primary-care physicians rather than by psychiatrists or psychologists. Although primary-care physicians are becoming more sensitive to emotional disorders, there is a chance of misdiagnosis.

Once the depressed patient gets over the hurdle of diagnosis, he faces some twists and turns on the road to recovery. With his doctor (primary-care or psychiatrist), he will work out a therapy plan, probably starting with medication and psychotherapy. Some patients experiencing mild depression may try St.-John's-wort or other alternative remedies. A small percentage may ultimately elect to have electroconvulsive therapy (ECT), a treatment with a controversial reputation but an 80 percent success rate, especially in cases where psychotherapy or medications haven't worked.

Many doctors also recommend paying attention to lifestyle triggers: "Depressives tend to be especially sensitive to disruptions in the circadian clock," reports Dr. Frederick Goodwin. "So I tell them they need to respect their sleep–wakefulness cycle. And exercise is important in two respects: one, for its metabolic effect on the brain, and two, because it regulates the body clock. You should exercise at the same time every day. Diet should be geared to minimizing blood-sugar variations—they're not good for brain function and can mimic symptoms of depression. Alcohol affects the same neurotransmitters that are involved in depression."

THERAPY VERSUS MEDICATION "The most dramatic shift in the treatment of depression over the last ten years has been the rebirth of psychotherapy," says Dr. Goodwin. "New studies using methods of psychopharmacology and focusing on therapies that take shorter periods of time than the old analytic model have shown synergistic effects between psychotherapy and medications." The debate about pills *versus* talk today is irrelevant. "I would say do it all," says Nada Stotland, M.D., M.P.H., chairman of the psychiatry department at Illinois Masonic Medical Center in Chicago. "Depression can be a life-threatening condition, and in reasonable hands neither the new medications nor talk therapy will do harm. Maybe you'll never know which helped you, but if you end up feeling better, who cares?"

Dr. Cochran points to recent data showing that talk therapy by itself works for mild to moderate depression, but that with moderately severe to severe depression, talk alone is not as effective as drug therapy coupled with some form of psychotherapy. "I had a patient who said she'd been depressed for about three months," Dr. Cochran explains. "Her concentration was lousy and her self-esteem was low. Her energy level was OK, her appetite was fine, her sleep was normal and she wasn't suicidal. She was having no trouble with her day-to-day activities, taking care of her husband and her kids. Since she had only the two symptoms, she didn't meet the criteria of five symptoms required for a diagnosis of clinical depression, and since she had begun feeling bad only three months before, it wasn't dysthymia. So I decided against medication. I learned that she had recently given up a high-powered job to move to California with her family. She was feeling conflicted about her new role of being just a mom to her young kids, about giving up the status of her old job. Once we looked at the issue and she sorted out what was important to her, the symptoms went away."

If, however, the downward-spiraling mood takes on a life of its own, separate from the triggering event, and the patient begins to dwell on the emptiness provoked by it, the endless accumulation of losses in her life, the guilt and shame of not being able to control her emotional deterioration, she may be

NATURE'S HEALING TOUCH

- **St.-John's-wort, whose active ingredient is *Hypericum perforatum*, has been widely used in Germany—where the drug is dispensed by prescription—to treat mild depression. Studies are under way in the U.S. to substantiate the German reports. St.-John's-wort is cheaper than prescription antidepressants and appears to have fewer side effects, though it can cause nervousness, stomach problems and photosensitivity. Since it doesn't require FDA approval, however, there's no uniform quality standard. It is inadvisable to take St.-John's-wort if you are taking the protease inhibitor Indinavir or the anti-rejection drug cyclosporine.**
- **SAM-e, Italy's version of St.-John's-wort, has been used there to treat depression for more than two decades.**
- **5HTP is extracted from the seed pods of the African plant *Griffonia simplicifolia*. The natural compound is linked to the production of serotonin in the body and may relieve depression in much the same way as SSRIs.**
- **Omega-3 fatty acids are found in oily fish, leafy green vegetables and various seeds. Studies are under way to see if patients who don't respond to antidepressants can be helped by pharmacological doses of omega-3 fatty acids.**

confronting major depression. She can be taught to redirect her negative thoughts (that is psychotherapy's role), but only after the downward cycle has been stabilized enough that she can focus on the therapy—that's medication's role.

ANTIDEPRESSANTS: THE PROS AND CONS

From the moment Prozac was introduced in 1987 as a "miracle cure," it has been buffeted by controversy. It was the first of a class of antidepressants known as selective serotonin re-uptake inhibitors, or SSRIs, which quickly became the most common treatment for depression. Seventy percent of patients got relief with the first drug they were prescribed.

SSRIs (among them Prozac, Paxil and Zoloft) work by targeting serotonin, one of the chemicals that help the neurons involved in the mood-regulating system of the brain to communicate with each other. The impact that these medications have on people's moods, the way they perceive things, and their ability to enjoy life has led researchers to believe that thoughts, perceptions and feelings are rooted to a surprising degree in the brain's biochemistry.

Serotonin, most researchers believe, is particularly important in regulating mood, and depressives appear to have too little of it. By making more available, SSRIs relieve the patient's symptoms. Still, serotonin affects more than mood—it influences everything from sexual behavior to digestion. Researchers have begun sorting out the many different receptors that are involved in serotonin's various functions, and in an effort to reduce side effects, they are homing in ever more tightly on those receptors that affect only mood.

SSRIs are a major improvement over previous antidepressants—the tricyclics and monoamine oxidase inhibitors (MAOIs). The older drugs aren't as targeted, altering the levels of many different brain chemicals, including dopamine and norepinephrine. As a result, these drugs, though equally effective as SSRIs, influence a wider range of brain functions and spawn a wider range of side effects. More important, both can be deadly if the patient overdoses. SSRIs are unlikely to be deadly even with an overdose.

But the new wave of antidepressants have fallen far short of ending depression in our time. As many as 30 percent of patients respond to the medications only partially or not at all. Some find that the drugs' effectiveness begins to wane over time; still more can't bear the side effects: SSRIs can cause jitteriness, sexual dysfunction, headaches, sleep problems and weight changes. They can be dangerous when taken in combination with MAOIs. (One of the newest drugs on the market, Celexa, eliminates some of the side effects by being even more selective in targeting serotonin receptors.)

Many of the questions generated by the stupendous growth in antidepressant use remain unanswered. Is it too easy to dispense pills whenever a patient complains of being a bit depressed? Is it possible that a quick fix of medication relieves the symptoms but masks the "real" problems, leaving them bottled up and dangerously unresolved? "At some point the patient must take personal responsibility for his own well-being, or the relief will be temporary," offers Ralph Carl Mumpower.

As Tracy Thompson tells it, "A turning point came in February 1990. I'd tried everything I knew to endure this life and I just couldn't do it anymore. Luckily, I had enough sense to call an old boyfriend and say 'I'm in serious trouble.' He came right away and took me to a hospital.

"The doctors took one look at me and told me I was severely depressed. Suddenly it hit me. I'd been fighting this illness for all those years, and I really didn't know. Then I started reading, educating myself about it. I realized I wasn't bad or defective. I was sick and I could get better. Most of the time, I can manage this illness."

A GLOSSARY

ANXIETY Feelings of fear and dread when circumstances don't warrant it; includes phobias, panic attacks, obsessive-compulsive disorder and posttraumatic stress disorder.

BEHAVIORAL THERAPY Deals directly with immediate problems. Destructive behaviors are identified and discouraged; rewarding behaviors are encouraged.

BIPOLAR DISORDER (MANIC-DEPRESSIVE DISORDER) In most patients, manic episodes alternate with depression. The mania can range from euphoria to irritability. Thinking seems to be at warp speed; ideas are grandiose, even paranoid. Judgment is compromised; behavior is reckless.

CLINICAL (MAJOR) DEPRESSION exists if the patient exhibits daily, for more than two weeks, five of the nine *DSM-IV* symptoms, which include lack of interest in usual activities, depressed moods, insomnia or hypersomnia, weight changes, inability to concentrate, restlessness or lethargy, loss of energy, feelings of worthlessness or guilt, and thoughts of suicide.

COGNITIVE THERAPY trains the patient to compare distorted thoughts to demonstrable facts in the outside world. "I am worthless" is an idea that can probably be disputed by gathering objective evidence.

DYSTHYMIA is a mild, though chronic, form of depression, with no sudden onset.

INTERPERSONAL THERAPY addresses life events that are potential triggers of depression (death of a loved one, changing a job, divorce, children leaving home). The therapist helps the patient connect his feelings to these events.

NERVOUS BREAKDOWN A term never used by doctors but often used by patients to describe the moment when they can no longer hold it all together.

SEASONAL AFFECTIVE DISORDER (SAD) is related to the shorter daylight of fall and winter. SAD can cause lethargy, sluggishness, the blues, overeating and oversleeping. Some patients respond to light therapy.

POSTPARTUM DEPRESSION follows the birth of a child, with symptoms of major depression; **PREMENSTRUAL DEPRESSION** affects some women just prior to and during their periods. Its symptoms are the same as dysthymia's.

HIGH ANXIETY

The bad news: if you're depressed, you have a 50–50 chance of suffering anxiety too. The good news: an array of potent therapies can keep it at bay. BY EVE GLICKSMAN

JUDY WALTERS WAS STARTING UP HER ACURA LEGEND when the panic struck. Suddenly terrified that her brakes would fail, she drove to a mechanic, breath short and heart racing. To her surprise, the brakes were fine. "It was me," she says. Walters, vice-president of public relations at the Investor Relations Group in Manhattan, had developed an anxiety disorder.

She was not alone: anxiety, like depression, is one of the most common, and most underdiagnosed, mental disorders—suffered by as many as 19 million (14 percent of) Americans.

Anxiety takes a bewildering array of forms: panic disorder (recurrent panic attacks marked by overwhelming fears of imminent death or disaster); phobias (intense fear and avoidance of a specific thing or circumstance, such as animals or social situations); obsessive-compulsive disorder, or OCD (uncontrollable, repetitive behaviors or thoughts); posttraumatic stress disorder, or PTSD (recurrent, distressing dreams and memories in the wake of an accident or violent crime); and generalized anxiety disorder, or GAD (ongoing, unfounded worry about family, finances, health, etc.). These disorders also include physical symptoms—shortness of breath, heart palpitations, muscle aches, gastrointestinal upsets, fatigue and insomnia.

"Anxiety disorders can be divided into two types," says James Potash, M.D., assistant professor of psychiatry at Johns Hopkins School of Medicine. "One type is a disease, such as panic disorder or OCD. You can be perking along, living happily, and then you start having these novel, strange panic attacks or obsessions. The other type of anxiety is more a reflection of a temperament. Some people are, in common parlance, 'worriers.' The anxiety they experience is an interaction between their temperament and the major or minor events in their lives."

He adds a third category: anxiety as a secondary symptom to depression, which is "extremely common." The implication, scientists believe, is that both anxiety and depression reflect (among other things) imbalances in norepinephrine, serotonin and dopamine, the neurochemicals that regulate mood, thought and movement. But much remains unknown.

The patient with coexisting anxiety and depression may be whipsawed mercilessly by the symptoms. When Shannon Robshaw, executive director of the Mental Health Association of Louisiana in Baton Rouge, was first diagnosed with depression five years ago, "psychotherapy helped dramatically." But another therapist then diagnosed a serious anxiety disorder whose symptoms included insomnia and chest pain. As Robshaw struggled with these, her depression returned. "By the time I got in to see a psychiatrist, I was desperate." For the next two years she continued psychotherapy and also tried various medications, ending with the antidepressant Celexa. "It seems to work for both the anxiety and the depression."

ANXIETY STAKES OUT NEW TURF A new group of people have emerged as overanxious and underdiagnosed: those over 65. Studies suggest that 20 percent of these men and women suffer some form of excessive anxiety, and that at least 10 percent have full-blown anxiety disorders.

In this age group, phobias—like that which ultimately forced Judy Walters to give up driving—are the most common anxiety disorder, says geriatric psychiatrist Gary W. Small, M.D., director of the Center on Aging at the University of California, Los Angeles. After phobias, GAD is seen most often. "Things hit you harder. The rubber band doesn't snap back when the stressful situation goes away," says Jenna Stiles, a motivational speaker and trainer with GAD, who also facilitates an anxiety and depression support group at the Mental Health Association of Arizona in Phoenix. She notes that anxious people are often perfectionists; a highly accomplished 70-year-old may agonize over simply forgetting a name. Real-life concerns also play a role: after her husband's death, folk artist Betty Nathan, 73, of Savannah, Georgia, sought help for anxiety about being on her own for the first time in her life. And Judy Walters believes her fear of driving—and, later, of escalators—reflected her fears about losing control in midlife. "Feeling like I couldn't put on the brakes was a metaphor for not being able to halt the aging process."

WHEN TO START WORRYING When does normal, everyday worry cross the line into pathology? "People come to see

OPTING FOR MEDICATION

Below are the drugs commonly used to combat anxiety. (Caveat: if you are over 65, the risk of drug interactions and side effects increases. Consult your physician.)

BENZODIAZEPINES (Xanax, Serax, Ativan, Valium) are antianxiety/sedative agents. They excel at short-term relief but are habit-forming and must be tapered off gradually.

BUSPIRONE (BuSpar) takes several weeks to work; preferable to benzodiazepines because sedation/dependency is rare.

ANITDEPRESSANTS Of three types, selective serotonin reuptake inhibitors, or SSRIs (Prozac, Paxil, Zoloft), are prescribed most. Patients with depression and anxiety may need a tricyclic antidepressant (such as Norpramin).

me when their anxiety is interfering with their ability to work or to conduct normal relationships with family and friends," says Dr. Potash. "The most dramatic example of serious anxiety," he adds, "is when people become suicidal. Typically, it's mixed depression and anxiety that leads a person to such intense despair."

Getting an accurate diagnosis is imperative; it guides the treatment regimen. "If someone comes in with lots of depressive symptoms and also lots of anxiety symptoms," says Dr. Potash, "one key thing is, Has she always been anxious, or did the anxiety begin at the same time as the depression? If the two clearly coincided, I would expect that by treating the depression, I'd also treat the anxiety. But if she's always been anxious, and if her anxiety is severe, she may need psychotherapy just for that."

Among older people, diagnosis can be especially tricky. "When a patient says, 'I'm short of breath,' the physician's initial reaction is to work up the heart and look for physical problems," says geriatrician Robert A. Zorowitz, M.D., medical director for senior services at DeKalb Regional Healthcare System in Decatur, Georgia. Or, regrettably, geriatric anxiety may be shrugged off: "What do you expect? He's 82."

TREATMENT CHOICES Once diagnosed, anxiety disorders are highly treatable. Eliminating substances such as coffee, alcohol and cigarettes is usually the first step; the next may be medication, whether antianxiety (anxiolytic) drugs or antidepressants. (The drug-averse may also wish to investigate alternatives such as St.-John's-wort, kava, Siberian ginseng and valerian.) Though Dr. Zorowitz estimates that three out of four of his anxious patients have been helped by medication alone, the conventional wisdom holds that drugs are most effective when coupled with psychotherapy. "Psychotherapy is helpful for every patient who has serious anxiety and/or depression," affirms Dr. Potash, "because these disorders affect the way people think about themselves and interact with people around them."

Anxiety sufferers may need to experiment. Betty Nathan's insomnia was relieved by the antidepressant Paxil. Jenna Stiles uses three-times-a-week yoga and two drugs—the antidepressant Elavil and the anxiolytic Ativan—to prevent panic attacks. And Judy Walters conquered her escalator phobia through behavioral therapy (the treatment of choice for phobias), desensitizing herself through repeated exposure.

The pity is that so many people just choose to live with high anxiety. "Cut yourself some slack and get help," urges Walters. "It's scary to fear something you used to be able to handle, but it doesn't make you less worthy as a human being."

For more information, contact the National Institute of Mental Health, (888) 826-9438, www.nimh.nih.gov/anxiety; or the National Mental Health Association, (800) 969-6642.

DESCENT INTO HELL

When depression strikes the highly successful individual, the very traits that once sent him or her aloft may speed the downward spiral. BY DIANE GUERNSEY

"I WASN'T FEELING PARTICULARLY MOROSE, JUST kind of anxious," says Richard Stanwood (not his real name), describing the tidal wave of depression that bowled him over, a bit more than a year ago, at the peak of his career as a media executive in Manhattan. "But I wasn't sleeping well, and I'd lost my appetite. Then there came a critical moment when I was sitting in my office, and my heart started racing very dramatically. I called my doctor and said, 'I've got to see you *now*.'"

After ruling out the possibility that Stanwood, in his mid-40s, had suffered a heart attack or had some other physical ailment, his doctor suggested that he see a psychiatrist. "As we talked, he said, 'It sounds like you have some symptoms of depression,'" Stanwood recalls. Thus began his journey as one of an oft-unsuspected (and unsuspecting) group: the gifted and glittering high achievers who also suffer from depression.

When a man or woman whose accomplishments have won admiration falls prey to depression, the observers' first reaction is to wonder: How could it be? This is someone securely wrapped in the golden mantle of success—bursting with talent, drive and passion for his or her chosen pursuit. In fact, these individuals are the best proof that depression—arising as it does out of the intricate minuet of mind, body and environment—cuts across all walks of life. And ironically, when these hitherto highflying men and women are jerked out of a soaring career arc and into depression's free fall, they often find that the talents and resources that once lofted them high now hamper their efforts at escape.

"It's worse, in some ways, if you can 'do it all,'" says Martha Manning, Ph.D., a clinical psychologist whose book *Undercurrents: A Life Beneath the Surface* (HarperCollins, 1996) describes her plunge into and reemergence from major depression. "People feel so ashamed that they can't do what they used to do: stay on top of everything. Often very high-functioning people can fake it for a long time. On one hand, it's good because there's something important in your life to keep you going, but on the other, it's bad because it keeps you from getting help, and you can get in way over your head. I believe that's what happens when you hear of suicides of very accomplished people; they've hidden it for a long time."

THE PERILS OF PERFECTION For the ultra-accomplished, the first major barrier to getting treatment is the sheer difficulty of acknowledging the possibility of depression. "When you have a history of success, and you've developed a feeling of invincibility," Richard Stanwood points out, "showing a crack in the armor is antithetical to who you are."

In his case, his struggle with depression (combined, as it often is, with anxiety) was worsened by his dread of following in the footsteps of his two siblings, both of whom had suffered from serious mental illness. "When my doctor suggested that I see a psychiatrist, I wasn't surprised; I'd seen mental illness and was aware of many of the symptoms," he says. "At the same time, it added to my fears, because I'd seen how much my siblings had struggled and suffered over the years. And I wasn't sure I'd ever recover."

The impulse, naturally enough, is to try to ignore or deny the gathering cloud of symptoms. "In my case, I needed to pull back from a very high-pressure, stressful job situation," says Stanwood. "But I was so used to achieving that my first thought was, 'Give me a pill and let me get back to work.'" While taking the drugs his doctor prescribed (first Zoloft, then Paxil), he says, "I tried to keep up my usual pace—flying to meetings around the country, in and out of different time zones—all the while feeling terrible."

Over the following six weeks, he felt increasingly despondent. Although the drugs' benefits took four to six weeks to show, their side effects (dry mouth, fatigue, increased anxiety) emerged immediately. "There was a downward spiral where I had this incredible feeling of being overwhelmed," he recalls, adding, "You know, when you are the leader of an organization, your ability to lead is based on your confidence in yourself and on other people's confidence in you, often through very tough times. One of the horrible things about depression is that it strikes at the very thing that makes you strong—your confidence. Also, you're making hundreds of decisions a day, many of them close calls, and depression strikes at your ability to reason. There's a real change in your thinking; the prism through which you see the world is skewed." Why didn't he just quit? "I'd never quit anything in my life," he answers. "The other thing is that, since I was a team leader, the notion of leaving my team just wasn't in my vocabulary. Anything I had ever done, I had conquered by just working harder, so the more impossible it seemed, the harder I worked, because those were the only tools I had." Finally, he says, "I was feeling so bad that I had to say, 'I'm taking a leave of absence.'"

The resulting avalanche of publicity almost wiped out his sense of relief. "Most people, if they suffer something like this, do it in a reasonably private way. But within minutes of announcing to my staff that I was taking a medical leave, there were reporters calling to get the story; the next day it

was reported in the paper. People from literally all over the world were calling my home," he says. "It added to the difficulty."

Even if you don't face a media blitz, there can be other obstacles to admitting there's a problem. From her mid-20s on, Martha Manning suffered on and off from what she now recognizes as depressive symptoms—but they were masked by her bustling drive to excel. "I was always in situations that were so demanding that I could point to them and say, 'That's what's making me feel like this,'" she says. "After doing my postdoctoral fellowship at McLean Hospital/Harvard Medical School, I came to Washington, D.C., and started doing all these things: being a psychology professor, becoming the PTA vice-president when my daughter was in first grade, overachieving at church. But gradually I found that my old way of handling things—to go faster and harder—wasn't working. I had to expend more and more energy to stay in the same place." In response, she entered into psychotherapy. "It was very, very helpful in getting me to recognize what a perfectionist I was. But when my therapist also said, 'You're depressed,' I didn't accept that."

Reluctantly, Manning did consult a psychopharmacologist and begin taking antidepressants. And her symptoms finally came into clear focus. "There came a moment when I was interviewing a new patient, an extremely successful attorney," she says. "You know, as a psychologist, you're diagnosing for depression all the time; I was going through the *DSM* [*Diagnostic and Statistical Manual of Mental Disorders*] checklist with her, and as I was checking off answers for her, I was also checking them off for myself. She had five out of nine symptoms, and I had nine out of nine." Finally convinced, Manning embarked on a period of trial and error with a series of antidepressants and tranquilizers.

THE STIGMA OF IT ALL Why would such people as Stanwood and Manning—first-class troubleshooters, intelligent, resourceful—fight so fiercely against the realization that something was going seriously wrong in their lives? Part of the answer lies, ironically, in the high premium that they—and society—had placed on their competence.

Nada Stotland, M.D., M.P.H., a psychiatrist and psychoanalyst who chairs the department of psychiatry at Illinois Masonic Medical Center in Chicago, concurs. "Not rarely, we hear about someone who has committed suicide, and we are astonished, because he seemed fine, he was pleasant, he went to work every day. We all have read about or know someone like that. It's amazing how well you can hide depression—how horrible you can feel, getting not a wink of sleep, and still get up and go to work. You may sit on a board or do charity work, and even though you're depressed, your makeup will be on straight, and you'll be well dressed. People who are astute may notice that your zest is gone, but they usually won't ask. Or let's say you've lost your appetite, which is very typical, and you've lost weight. People will tell you how fabulous you look!"

This disconnect only feeds the despond, she says. "When you're clinically depressed, you can have a conversation, saying things like, 'Oh, doesn't she look nice!' or 'That's a pretty dress,' and inside you're having all these images of doom and despair. Or when you go out with friends, the food you're eating doesn't taste like anything, it tastes like straw, and you have to say, 'How delicious!'"

Add to a personal sense of failure and futility the actual or implied message, from others, that it's your fault, and the sense of alienation grows even greater. "My husband and my 12-year-old daughter were very aware of my depression, and my parents and siblings knew," says Manning. "But my husband did not tell his family; when I was hospitalized, he told them I was in for exhaustion. And my husband's a clinical social worker! It points to the stigma. Even well-educated people, who should know better, thought this was some failure of our marriage, or some failure within me."

As a society, says Dr. Stotland, we are confused about depression. "We use the same word for a bad mood as for having the disease. When you're in a bad mood, you're sup-

posed to keep busy, go to the movies with your friends, throw yourself into your work—basically the onus is on you to get rid of the mood yourself." Paradoxically, this attitude feeds into the high achiever's tough-it-out ethos—and presents another barrier to getting help.

SEEKING HELP AGAINST ALL ODDS When a depressed person does seek help, the path can be as tortuous as something out of *Catch-22*. "If you're clinically depressed, you're in a real double bind," Dr. Stotland says. "If things are tough in your life, your friends and your doctor may think, 'Well, no wonder you feel bad!' But I make the analogy to being hit by a truck. If I got hit by a truck and had a compound fracture in my leg, I wouldn't want my friends or a doctor to stand around saying, 'Well, of course your leg hurts!' I'd want medical treatment for it! Even if my depression were precipitated by my having cancer, or by my spouse's walking out on me, wouldn't the depression make dealing with it much harder? There's too much of a tendency to say, 'Well, no wonder.'

"And what if everything is good in your life?" she continues. "Then you think you don't deserve to feel bad. You tell your mother that you're depressed, and she says that you have two beautiful kids, your husband loves you, and look at your cousin whose husband left her and your sister who lost her job. So how dare you feel bad? It's not so easy."

Family and loved ones also feel stymied, notes Martha Manning. "They're worried about suicide, they have to take up the slack of daily living, they don't know whether the depressed person is ever going to come back—and then there's that person's irritability, the striking out at the one who's safest, the spouse." (See "When It's Your Partner.")

INTO THE SLOUGH OF DESPOND Once the depression is acknowledged and treatment is begun, the sufferer still faces a painful uphill slog. During his first few weeks on antidepressants, says Richard Stanwood, "I went from being the most optimistic person on earth to feeling hopeless and helpless. You think, 'My god, I have the best doctors in the world! I've sought help, I'm getting help, and it isn't helping!' I worried that modern medicine couldn't deal with this, that I'd lose my reputation and bring infamy on my family."

When his depression became paralyzing, Stanwood checked into a prestigious facility for mood and bipolar disorders and alcohol abuse. "For me, checking into the hospital was the greatest stigma of all," he recalls. "I wasn't suicidal, but I was in such agony. Before, I could never understand how anyone could contemplate suicide, but now I could." His treatment was relatively brief and straightforward. For starters, he switched to Prozac, which he found more effective than the other drugs. Just as important was the relief of letting go of his crushing sense of responsibility. "I checked my ego at the door," he says, laughing. "The trigger for my depression was stress, and going into the hospital took away all the stress. It wasn't so much the quality of care as the safety of the environment. For the first few nights, they'd check my room every fifteen minutes to make sure I hadn't hurt myself. As you get better, you go from thinking, 'Oh, good, they're coming by' to 'Hey, I'm trying to get some sleep here!'"

Stanwood also found help from an unexpected source. "In my hour of greatest need, the person who provided the greatest solace to me, out of all the doctors and health professionals and family members, was my big sister, who has bipolar disorder," he says. "She was the only person I'd talked to who had ever experienced a depression like mine. My biggest fear was that I would disappoint her, because I had always been more successful professionally, and yet here she was helping to save my life because of her experience. She was there for me 1,000 percent." After two weeks, he emerged feeling better. "Within three or four months, my strength and confidence were restored."

Martha Manning's depression followed a more circuitous course. Her antidepressants helped initially, but they lost their power after eighteen months—a pattern that repeated itself with other drugs. "Thoughts of suicide were becoming attractive to me," she says. Deeply concerned about her continued deterioration, Manning's therapist suggested electroconvulsive therapy (ECT), which is highly successful with severe depression that doesn't respond to other treatments. "At first I dismissed it," Manning says, "but two weeks later, I started ECT. The question had become, Do I live or do I die?"

Over the next three weeks, she had six inpatient ECT sessions. "I noticed an improvement after two treatments," she says. "For six months, I'd been extremely agitated, I hadn't been eating, I'd been getting only two hours of sleep every night. All of that got dealt with. I started adding twenty minutes a night to my sleep. When I came home, I still felt I'd been through the wars, but I knew I was getting better. Two weeks later I was doing the carpool, and two weeks after that, I was back at work."

Manning, who once shared the visceral shudder that most people feel at the idea of ECT, has changed her mind since her treatments. "People don't like it because it can cause memory deficits, but it has a 75 to 90 percent success rate. And medications that hadn't worked for me before seemed to work after I had ECT," she says. "It's as if it cleared the deck and brought me back to a certain baseline." Since then she has also used other treatments, including lithium, with good results.

THE AFTERMATH For both Richard Stanwood and Martha Manning, the descent into depression was a bit like Dante's descent into hell—a truly harrowing inferno followed by a return to the bright world, with a renewed sense of wonder and appreciation. Interestingly, each has made career changes: Stanwood is now "a happy entrepreneur," and Manning has reworked her role as a psychologist in favor of full-time writing and public speaking on the subject of mental illness—she no longer sees patients. And each has returned from the shadows bearing hard-won lessons to live by.

Stanwood discovered that depression did not, after all, have the power to wreck his reputation. "People were relieved. They'd say, 'Oh, good, you were only depressed—I thought you had cancer!' I was shocked at the number of friends and other people who said, 'You remember the month I was out with the flu? I was actually depressed.' There wasn't a person I talked to who hadn't experienced depression either himself or in a loved one. And within a very short period of time, I was offered other jobs." He still uses discretion, but "with any of my friends and colleagues, I'm very open about what happened, particularly if my experience can help them learn from what I went through.

"Actually, I would say it was the best thing that ever happened to me," he says cheerfully. "As intoxicating and wonderful as success is, often you get it at the expense of other parts of your life. I would've gone on climbing mountains—there are always other mountains to climb—but there were very important parts of my life that were missing, and it took a powerful event to make me reevaluate my life and ask, 'What will make me happy?'" He's found some exhilarating answers. "For one thing, I've fallen in love. I wouldn't have had the time or energy or inclination to let that happen before."

Manning discovered that the harm depression inflicts on your closest bonds can be mended. "My daughter Keara's middle name is my last name, but she dropped it after I went into the hospital," she says. "It was not until two-and-a-half years later, when she was graduating from high school, that she complained, 'Mom, it's going to be hard to fit my whole name on the diploma—Keara Manning Depenbrock.'"

Weaving through Stanwood and Manning's accounts is a golden thread of self-acceptance. "Part of what brought on my depression was a sense of hyperperfectionism and responsibility—that the weight of the world was on my shoulders," says Stanwood. If you are suffering from depression, he advises, "At the earliest possible moment, be honest with the people who are your safety net, your friends and family. Realize that you don't always have to be the go-to guy, and that it's OK to be human. It's like any disease; the sooner you catch it, the more chance you have for a speedy recovery."

He concludes, "I began to get better when I said, 'You know what, I'm sick—and I don't care about anything except getting better. I don't care about my big, fancy job, and I don't care about what other people are thinking. I just have to save my life.' That was the minute I started to get well."

ADVICE FROM THE FRONT LINES

Confide in someone you can trust. "Particularly if you're afraid that this will threaten your job, your standing in the community or your relationships, you need to talk to someone who's not going to be distressed by that and who can help you get the information you need," says Martha Manning. Information is available from the National Depressive and Manic-Depressive Association (800-826-3632), the National Alliance for the Mentally Ill (800-950-6264) and the National Mental Health Association (800-969-6642). The NMHA's new Web-site program, at www.nmha.org, offers a confidential screening test for depression.

Remember that coexisting conditions may mask a possible depression. "Many conditions occur alongside depression," Manning says. "A person may feel tormented by anxiety, but when you do the diagnosis, he comes up depressed. There's a 75 percent overlap between eating disorders and depression. And if a man who's depressed also has heart problems, he may say that depression is not affecting his life; but if he has a heart attack and doesn't get treated for any subsequent depression, the mortality rate is much higher."

Keep looking until you find the treatment or treatments that work for you. "Life can seem so overwhelming, but you need to realize that that's not life, it's the depression," says Shannon Robshaw, M.S.W., executive director of the Mental Health Association of Louisiana, in Baton Rouge. "There really are effective treatments these days. You may not find the one that works best for you immediately—sometimes the process takes many months—but you *can* find one."

Learn as much as possible about your treatments and their effects and side effects. This is particularly crucial for women, says psychiatrist Laura Miller, M.D., chief of women's services at the Center of Excellence for Women's Health at the University of Illinois in Chicago. "Recent studies demonstrate that psychotropic medications should be dosed differently for women than for men. In luteal phase dosing, the dose changes across the menstrual cycle. Other dosing programs depend on whether a woman is pregnant, breast-feeding, menopausal or postmenopausal. Women should ask their clinicians whether they're familiar with it."

If you are receiving treatment for depression, bring your spouse or partner into at least some sessions, advises Dr. Miller. "If there are other family members involved, I'll bring them in too. It helps to strengthen the person's support system."

Avoid "treating" your depression with alcohol or other nonprescription sedatives. "A lot of people I saw in the hospital were being treated for alcoholism and depression," says Richard Stanwood. "What they didn't realize is that alcohol is a depressant too! So the combination is a double whammy."

Learn about and avoid the triggers for your depression. "Avoiding it in the future means understanding what allowed it to happen in the past," advises Stanwood. "For me that means, number one, really finding out through psychotherapy what made me work myself so hard—work myself almost to death."

Learn what gives you pleasure and helps you to relax. "Try to be very conscious of the degree of stress you're under," advises Stanwood, "and do the things—whether it's reading biographies of Lincoln, playing your weekly golf game, or spending time with your children and your spouse—that allow you to de-stress."

WHEN IT'S YOUR PARTNER

How you help someone when depression strikes under your own roof can be a test of love—and a testament to love's power. BY JIM BROSSEAU

ANYONE WHO'S EVER WATCHED THE WILLFUL GRIP OF depression overpower a spouse or partner knows what a frustrating, even frightening, experience that can be. It presents you with an uneasy trio of challenges: a) establishing whether your loved one is, in fact, depressed; b) trying to get him or her to seek help; and c) maintaining your own well-being.

"The hard part is, I started blaming myself for what my husband was going through," says Maya (not her real name), a New York artist whose spouse has had at least two episodes of depression. "I'm his wife, not a stranger. And I thought conveying that alone—that I'm there for him—would be enough. But it's not. And what complicates it is we all have needs. When somebody's depressed, he can't even be there for himself; how can you expect him to be there for you?"

Maya, at least, was able to detect her husband's depression. But as is true of alcoholism, depression engenders denial among the various parties to it. So the nondepressed half of a duo must first accept the possibility that his significant other could be in danger. That means keeping an eye out not only for the classic symptoms—loss of appetite, problems with sleeping, etc.—but for the sometimes subtle ways depression manifests itself.

"Watch for more of a focus on the downside of things in day-to-day conversation, for example," says psychologist Norman Epstein of the University of Maryland's family-studies department. Small changes in a person's routine could be a clue, such as spending more time in front of the television than usual. Don't dismiss anything that strikes you as odd, experts say. "It's important to trust your gut reactions and take those feelings seriously," cautions Epstein.

Once you believe a problem exists, the next step is to convince the love of your life that professional help might be in order. If your spouse has never been in therapy and is male, this could be an uphill battle. "Men will call a plumber but won't call for help with a personal problem," notes Ralph Carl Mumpower, an Asheville, North Carolina, clinical and family psychologist. But gender aside, reaffirming your devotion to your loved one, Mumpower says, could ease him into therapy: "Let him know that his welfare matters to you. Let him first feel safe in informing you about how he feels."

What *not* to do? "Don't call him 'sick' or 'crazy,'" warns Constance D. Wood, a Houston psychologist who has counseled families for more than thirty years. "People don't need to be labeled; they need to be helped."

And if they continue to resist? "*Uhhh*," is California psychologist Teri Wright's knowing response to an all-too-common dilemma for caring partners. Among the few short-term options, experts agree, is to reiterate your concern; get other family members to reaffirm their own love through expressions of support; and be concrete in pointing out how the pall of depression is keeping him or her from the things he or she normally enjoys—always in nonjudgmental terms (i.e., "I know how much you love playing the piano," versus "How come you never play the piano anymore?").

If the symptoms persist for a matter of weeks, it may be time to get the help of your physician, a trusted clergyman or someone else outside the family circle who can validate your concerns. But if at *any* point in the downward spiral a person brings up suicide—or, as Wright chillingly puts it, "gets out his gun collection just to take a look at it"—action must be taken, even if that means dialing 911 in the most desperate of scenarios. (Under state laws, a person can be held involuntarily for up to ninety hours in a psychiatric facility if he's deemed a threat to himself or others.)

It's no wonder that the path of depression can exact a tremendous toll on any man or woman who's had to travel it within kissing range of someone he or she loves. Fortunately, there are support groups for the families of people battling depression. (Ask your physician or contact your local mental-health department for referrals.) Indeed, help is widely available today to both the person trapped by depression and the person who'd most like to set him free. With therapy, Maya's husband has been able to finally elude the darkness of his condition. "You gain a deeper understanding of just what commitment means," reflects Maya. "You love the whole person—he's the one I love. *He's* not his depression, even though it's sometimes a *part* of him."

Those who've faced Maya's challenge know that tears will be inevitable. But chances are they'll eventually be followed by the sound of your lover's laughter making a sweet comeback. As Teri Wright observes: "When I see people getting their sense of humor back, I know they're getting better."

Further reading: *When Someone You Love Is Depressed* (Fireside; $12), by Laura Epstein Rosen and Xavier Francisco Amador. *What to Do When Someone You Love Is Depressed* (Henry Holt; $14), by Mitch Golant and Susan K. Golant. *When Madness Comes Home: Help and Hope for the Families of the Mentally Ill* (Hyperion; $16.95), by Victoria Secunda. To order, call Books Now at (800) 962-6651.