

of the 40 percent of happiness that can be controlled, that changing your happiness level is entirely in your hands, that your "unhappy genes" do not doom you to unhappiness or, worse, to depression.

The recommendations in this book for how to become a happier person turned out to possess a surprising power, even for a seasoned happiness researcher like me. Without a doubt, writing the book has changed my life in some anticipated and many unanticipated ways. I hope that reading it will change yours and help you get the life you want.

Postscript

If You Are Depressed

If you scored in the "depressed range"—that is, 16 or above on the depression scale (the CES-D) printed in Chapter 2—you may be wondering what you need to know immediately and what special steps you can take in addition to those described here. I should stress, however, that although a program to become happier can positively be attempted by those who are depressed, relief from depression is not what this book promises. We'll now take a closer look at depression, what causes it, and what can be done about it.

What Is Depression?

Depression is an illness, not a failing. It's what psychologists call a syndrome—that is, a group of signs and symptoms that form a pattern. Many of you are undoubtedly already familiar with these symptoms. Some of you may only have a few of them, while others may have many. There

are nine classic symptoms, with the first two being most diagnostic of depression.¹

1. Sad mood for most of the day: feeling down, anxious, or "empty," though some of you may feel tense or irritable instead
2. Being less interested and finding less pleasure in almost all hobbies or activities that you used to enjoy (including sex)
3. Feeling excessively guilty, worthless, or helpless
4. Having little energy and feeling fatigued much of the time
5. Having a hard time concentrating, remembering, or making decisions
6. Having trouble sleeping: experiencing insomnia, early-morning awakening, or oversleeping
7. Having trouble eating: overeating and gaining weight or losing your appetite and losing weight
8. Feeling either agitated or slowed down
9. Having thoughts of death or suicide, making suicide attempts

It's important to distinguish clinical, diagnosable depression from a passing sad mood. Full-fledged depression involves your whole body and person—your feelings (e.g., "I feel wretched"), your thoughts (e.g., "I'm ugly"), and your physical state (e.g., "I can't sleep"). To make things more complicated, there are also different types of depression. The most common are the following:

- * Major depression, which involves one or more episodes (or periods of time) during which the depression is intense and you suffer a large number of symptoms. These symptoms interfere with your work and your relationships, in addition to disturbing your sleeping, eating, and enjoyment of once pleasurable activities.
- * Dysthymia, a less severe but more chronic (longer-lasting) type of depression. Your symptoms aren't as numerous or as disabling as in

major depression, but they keep you from feeling good or functioning very well. If you're particularly unlucky, you may have both major depression and dysthymia, a condition researchers call double depression.

- * Subsyndromal depression, in which you have some symptoms of depression, but they are not so intense or so long-lasting to earn you a formal diagnosis of either major depression or dysthymia. However, this type of depression deserves attention too, inasmuch as you may still feel miserable and impaired in your daily life.

Even within these classes of diagnoses, you may suffer from particular types of symptoms. For example, when women are depressed, they are more likely than men to experience weight gain, a boost in appetite, and increased need for sleep, called reverse vegetative symptoms. Men are more likely to experience the opposite and to feel angry and discouraged instead of hopeless and helpless. Furthermore, approximately one in ten adults (men and women) has depressed moods that cycle with the seasons, inflaming during the winter months. About one in twenty women has depressive symptoms that tend to appear during the week before her menstrual periods. Depression in women is also common after giving birth. Depression in older people is often triggered by a taxing illness or the loss of a loved one.

But no matter what kind of depression or what unique constellation of symptoms you have in particular, you must know that you *can* get better. Amazingly, the typical depressed person doesn't seek treatment for an average of *nine years* after experiencing her first symptoms.² So, even if you're pretty sure you are depressed or if you have been in the past, you may have never received help from a mental health professional. I urge you to do so without delay, for several reasons.

First is a problem called comorbidity. This means that if you are depressed, you are very likely to be experiencing one or two or even more other physical or emotional problems. Do you have persistent worries and

tension or irrational fears that you just can't shake? Have you ever had a panic attack, when you've felt that you might die? Do you have frightening nightmares or memories of a terrifying event? Do you have an eating disorder or a problem with smoking, drinking, or drugs? These are just some of the conditions that tend to accompany depression and must be managed and treated as soon as possible. Fortunately, several kinds of antidepressant medications have proved helpful not only in effectively relieving depressive symptoms but also in treating some of these accompanying conditions.³

The second reason to seek help for your depression is that it can wreak lasting damage on your life. Research shows that the toll depression takes is as great as that of a chronic physical disorder like diabetes, arthritis, or high blood pressure.⁴ Because the average age at which people develop depression is in their mid-twenties, the illness can have a profound effect on important life transitions, like finishing school, starting out in a career, becoming a parent, and getting and staying married. Furthermore, in the United States alone, the loss of productivity engendered by depression costs thirty-three billion dollars per year in salary.⁵

Some people argue that depression is "normal," that feeling sad or inadequate or hopeless about everything is not a sign of irrationality or illness. Some even argue that good things can come out of it. There is a kernel of truth in this. Some of the low moods we feel may be what Freud termed ordinary human unhappiness, and sometimes pessimism has value. That is, people with negative outlooks may be more vigilant about threats and dangers and thus heed warnings that optimists will not. But if you are depressed, you know all too well that what you are experiencing is not just a pessimistic view of yourself and the world. What you are experiencing is utter suffering and pain. Much of this suffering is unrelenting and awful and undeserved, and this is the biggest reason that depression needs to be resolved and relieved.

The Causes of Depression

SUSCEPTIBILITY AND STRESS

(OR NATURE AND ENVIRONMENT)

Many physical diseases develop when two things are present at the same time: First, we have an inborn susceptibility or predisposition toward the disease, and second, we experience some kind of event or stress in our lives that triggers it.⁶ Likewise, depression appears to be a result of both "nature" and "environment." Like heart disease or diabetes or arthritis, it is rooted in our biology. This is the nature part, involving our genes and brain function. The heritability of depression—that is, the extent to which it is genetically determined—ranges from 20 to 45 percent⁷ for milder forms and is likely much higher for severe forms. Indeed, a parent, child, or sibling of someone with depression has a two to four times higher probability of becoming depressed than the average person.⁸ It's clear that some of us are born with a susceptibility to depression. This susceptibility, which could be inherited or simply ill fated, is likely expressed in what happens in our brains. Many studies have found that people suffering from depression show unique symptoms in their bodies.⁹ These symptoms include too low amounts of various brain chemicals (norepinephrine, serotonin, and dopamine), a too high amount of a stress hormone (cortisol), and disturbance of deep dream-related (REM) sleep. Furthermore, new technologies allowing researchers to image the brain have revealed that severely depressed patients have abnormalities in the prefrontal cortex (the region of the brain responsible for thinking and managing emotions) as well as in the limbic regions (i.e., areas involved in sleep, eating, sex, motivation, memory, and responses to stress), including the mysterious-sounding Area 25.¹⁰ In sum, there is now a great deal of evidence that depression is partly rooted in those parts of our physical bodies over which we have minimal control.

However, a genetic or biological predisposition is generally not enough to precipitate depression. It's not the whole story. A stress or some

kind of trigger is necessary as well. If your predisposition is very strong, then a relatively minor stress could lead you to fall into a full-fledged depression. If your predisposition is small, then only a major stress or trauma will bring about depression.

What do I mean by *stress*? The trigger that makes you depressed could be stress in your life, although it's likely to be severe stress—for example, the stress of poverty or a traumatic life event (like experiencing violence, a natural disaster, or the loss of one's home), separation or divorce, serious or chronic illness, caring for a sick child or aging parent, and many others.¹¹ Alternatively, some researchers focus on bad experiences in childhood as the stressors that trigger depression in adulthood. Indeed, many different kinds of poor parenting, including whether your mother was depressed or anxious while pregnant, as well as whether your parents were neglectful, intrusive, harsh, inconsistent, or abusive, have been blamed for later depression. Unfortunately, researchers don't know whether it's the inadequate parenting that leads to later depression in their kids or something else entirely, like depression-prone genes shared by the whole family.

PSYCHOLOGICAL VULNERABILITY

What else can cause or activate a depression? Many tomes have been written on this subject, and I shall only mention the two theories backed, in my judgment, by the most scientific evidence. The first is Aaron Beck's cognitive theory of depression, which forms the basis for the most commonly used psychotherapy for this illness, cognitive-behavioral therapy. Beck is a psychiatrist who argues that some people have dysfunctional attitudes that make them vulnerable to becoming depressed in the face of a negative event. These maladaptive attitudes often involve the notion that our happiness and self-worth depend on our being perfect or hinge on other people's approval. For example, we might think, "My teacher's critical comment means that I'm a total failure" or "If my girlfriend doesn't love me, then I am nothing." If we share these beliefs, then when something truly bad happens, we tend to have automatic negative thoughts

about (1) ourselves (e.g., "I'm not lovable"), (2) our present experiences (e.g., "My boss always prefers my coworkers"), and (3) our futures (e.g., "I'll never outgrow my shyness"). Beck calls these types of thought a negative cognitive triad.

A related explanation for depression, called hopelessness theory, came out of the work of Martin Seligman and his students. According to this theory, having expectations that bad things will happen to us and that really good things will *not* happen, and that we cannot do anything to improve the situation, can cause depression. Thus hopelessness is thought to lie at the root of a depression. How does a person become hopeless? When confronted with stressful or otherwise negative experiences, some people draw harmful inferences or conclusions. For example, when a man fails to get an expected promotion, he may conclude that being passed over (1) "means I don't have talent," (2) "will prevent me from ever advancing in my career," and (3) "proves that I'm unworthy." These are symptoms of hopelessness, and they are likely to trigger depression in such a person. In contrast, another person in the exact same situation may be protected from hopelessness, and thereby from depression, if she alternatively concludes that (1) "I haven't been putting much effort into my job lately," (2) "I should work harder, so I could get the promotion next year," and (3) "this has no bearing on my self-worth."

Both hopelessness theory and Beck's cognitive theory assume that people who become depressed have a cognitive vulnerability—that is, a dysfunctional way of thinking about negative life events that makes it more likely that they'll become depressed. Simply put, how we interpret our life experiences (e.g., current problems in a relationship) influences our feelings about those experiences (e.g., feeling hopeless and inadequate versus confident and optimistic), which ultimately lead to distress and even full-fledged depression.

An exciting recent project, the Cognitive Vulnerability to Depression Project, has followed participants over time, measuring both their maladaptive thoughts and their life stresses. It has found that indeed, those participants with hopeless and dysfunctional attitudes at one time are more likely to suffer a major depressive episode at a subsequent time.¹²

Fortunately, cognitive therapy, as you will shortly learn, has been very effective at attenuating these maladaptive attitudes.

RISK FACTORS FOR DEPRESSION

A risk factor is something that makes depression more likely, without necessarily causing it. There is now a great deal of scientific support for three risk factors for depression:

1. Poor social skills
2. Shyness or withdrawal
3. Excessive dependency on others

If you recognize any of these qualities in yourself (and it's possible to possess more than one), obtaining professional help may be extremely valuable. First, if your social skills need improvement, you can learn how to express yourself and communicate better, to control your emotions and be sensitive to others' feelings, and to initiate and hold your own during conversations. Researchers have also found that people who have poor social skills have a tendency to seek criticism from friends and family; indeed, they gravitate toward people who reject them. This is also something that a psychotherapist can help you resolve.

Second, if you are the type of person who avoids social situations or is excessively shy, you may be predisposed to experience depression. This is probably because in the face of stress or negative events, shy or inhibited people avoid the very things that can protect them from falling into a negative spiral—namely, companionship and social support.

Finally, if you constantly seek reassurance from other people about your worth and lovability or if you are extremely needy of others' acceptance and support, then you may be characterized by so-called excessive interpersonal dependency. As with the other risk factors, having this characteristic makes you vulnerable to becoming depressed. Again, excessive dependency should be worked out in a therapeutic context.

The Most Effective Treatments for Depression

This section could take up the space of an entire book—or a shelf—because there are many, many treatments for depression. Hence I shall only discuss the small handful of treatments that, in my opinion, have the strongest empirical support—namely, the four most effective therapies. One is pharmacological therapy, otherwise known as antidepressants or meds. The other three are types of psychotherapy (or talk therapy): cognitive-behavioral therapy, interpersonal therapy, and marriage and family therapy. The current wisdom is that people with mild depression do very well with psychotherapy, but those with moderate or severe depression may significantly benefit from antidepressants.¹³ Most, however, do best with a combination of medication and psychotherapy, the medication to provide swift relief from symptoms and the psychotherapy to teach skills so that the depressed person can independently solve her problems and manage her depressed feelings and thoughts. We'll begin with the best psychotherapies.

COGNITIVE-BEHAVIORAL THERAPY

As mentioned earlier, Beck's cognitive theory of depression gave rise to this, the most widely used depression therapy. The focus here is on your thoughts. Cognitive-behavioral therapists assume that those who are prone to depression are overly negative in their perceptions of themselves, their worlds, and their futures (that negative cognitive triad again) and that such people show distorted thinking. For example, a depressed person might come to the therapist's office and declare that she's a failure because it rained at her son's swim party the day before. The job of the therapist is to teach the depressed patient to recognize and dispute her negative beliefs and to replace them with more adaptive thoughts. The therapist might engage in a dialogue with the patient about the circumstances of the child's party until the patient realizes that her thinking has been

irrational and unduly pessimistic. "Homework" may be assigned between sessions to reinforce the therapist's instruction and guidance.

So that's the cognitive part. The behavioral part consists of teaching depressed patients skills that they might lack, such as problem solving (i.e., teaching you how to define life problems and helping you generate possible solutions to those problems and choose among them), self-control (i.e., teaching you to set weekly goals and then to monitor your behavior and reward yourself for meeting those goals), and so-called behavioral activation (i.e., encouraging you to take action rather than avoid difficult situations). The main goal of behavioral therapy, however, is to engage depressed individuals in activities that they enjoy and that afford them a sense of mastery. Not only will this strategy increase positive emotions, but it will also distract the depressed person from overthinking—or ruminating—about her feelings and problems, making the depression even worse.¹⁴

Cognitive-behavioral therapy is relatively short term, usually lasting from four to fourteen sessions. However, treatment is likely to be longer for those with extensive histories of rigid dysfunctional thinking. Patients with long-standing and entrenched maladaptive beliefs are taught to recognize that much of their distress stems from these beliefs, and not just from the negative life events that they've experienced. In other words, it may not be the breakup six months ago that's making you depressed but your continued maladaptive ruminations about it.

Is cognitive-behavioral therapy effective? The short answer is yes. This type of therapy has been one of the most extensively tested of all depression treatments and has been shown to be equally or more effective than other psychotherapies and roughly comparable to medication.¹⁵ Furthermore, those treated with cognitive-behavioral therapy until their depressions have lifted (i.e., until "remission") are less likely to relapse or to suffer from a future depressive episode.

INTERPERSONAL THERAPY

If you're depressed, you are likely to have at least one interpersonal problem—for example, you may be grieving the loss of someone close to

you, dealing with a failing marriage or a stressful life transition, or suffering from a lack of assertiveness. Although it's loosely based on Freudian psychoanalysis, interpersonal therapy uses an eclectic approach, borrowing the best techniques from a handful of other therapies. For example, when the assumptions of medical doctors are applied, the depressed person is defined in this therapy as having a medical illness, which is treated and not the result of a personal defect or weakness. Furthermore, marital therapists, interpersonal therapists help you work on and solve your relationship problems, instilling optimism in you that doing so both improve your personal situation and relieve your depressive symptoms. Finally, like cognitive therapy, interpersonal therapy is focused on the here and now, not on excavating the unconscious basis of depression in childhood.

This therapy takes three to four months. The focus during the sessions is on addressing your recent and ongoing interpersonal events—whether they involve marital strife, a child's disability, or the loss of friendship and the therapist's strategy depends somewhat on the type of event that is problematic. For example, if your greatest concern is conflict with your mother-in-law, the interpersonal therapist will talk with you about the disturbed relationship, the exact nature of the conflict, and what you need to do about it. He will help you re-create your situation so that you fully understand it. The therapist will then go over with you all the options that you have at your disposal to resolve the problem, and the therapist may have kept you from seeing or exploring fully. Together you may engage in role playing at this point to rehearse possible strategies such as what you would say when confronting your mother-in-law or a grievance.

Studies have shown that interpersonal therapy is very effective at treating depression. Its efficacy is close or equal to that of antidepressant medication and even superior to medication at improving social functioning. If you think this type of psychotherapy is a good fit for you, then it may be a vital treatment.

MARRIAGE AND FAMILY THERAPY

Like interpersonal therapists, marital and family therapists recognize that depressed individuals often have problems with family relationships. Indeed, if you are married *and* depressed, you are very likely to be experiencing distress in your marriage.¹⁷ If you are depressed and have children at home, you are probably experiencing difficulty in the area of parenting.¹⁸ Serious depression can cause pain and suffering not only in the ill person but in his or her family. But is it the family problems that cause depression or vice versa? According to stress-generation theory,¹⁹ whose logic guides most marital and family therapists, the causal arrow runs both ways. There are many ways that depressed individuals can create stress in their interpersonal relationships, and this interpersonal stress can make them even more depressed. For example, depressed women are more negative and pessimistic toward their partners, are more lax and inconsistent mothers, have more strained relationships with their teenage children, and are more likely to withdraw during conflicts. All these factors make it likely that the depression exacerbates these women's family troubles. On the other hand, marital problems (an infidelity or the threat of divorce) and parenting problems (constant strife with kids) increase the risk of depression or aggravate the depression that's already present.²⁰ This vicious cycle, in which depression leads to problems, which lead to more depression and more problems, is where the marital and family therapist can intercede.

The two most common and successful interventions for the kinds of family troubles commonly experienced by depressed individuals are behavioral marital therapy for marital discord²¹ and parent training for child management problems.²²

Behavioral marital therapy is a relatively brief treatment in which the therapist meets regularly with the depressed person and his or her partner. In the first phase of treatment, the therapist tackles the biggest strains on the relationship and helps the couple have more positive interactions. The couple may be given a homework assignment to figure out what activity they have enjoyed doing together in the past and then going ahead and doing it. When this phase is successful, the depressed person is already

feeling brighter and both partners are expressing positive feelings toward each other. This boost serves as the foundation for the second phase, whose aim it is to restructure the relationship—for example, to improve the way that the couple communicates, handles problems, and interacts on a daily basis. Sometimes this is done by having the couple write a behavioral "contract," agreeing to change aspects of their behavior. When successful, this phase will leave the couple feeling more supportive and sensitive to each other's needs, more intimate, and better able to cope with future difficulties. Finally, in the third phase, the therapist helps the two partners prepare for stressful situations that might come to pass and encourages them to attribute their improvement in therapy to their love and caring for each other. Interestingly, behavioral marital therapy has been found to be at least as effective as individual therapy at lifting depression. However, it has the additional benefit of bolstering marital satisfaction. Indeed, a number of studies have shown that the boost in marital happiness (or favorable changes in the marriage related to that boost) is in fact the *reason* that the marital therapy works.²³

Unfortunately, marital therapy suffers from a considerable obstacle: Its success hinges on the depressed person's partner's not undermining the whole process or refusing to participate altogether. This does happen occasionally (though less often than it did twenty-five years ago), because some people consider such therapy a stigma. An alternative is to consider parent training as a first step because depressed individuals are likely to have difficulties in both the arenas of parenting and marriage. Relative to marital therapy, parent training is much more widely accepted, is considered less embarrassing, and doesn't require the participation of both parents. Different types of parent management training exist, but most teach parenting skills (e.g., the use of reinforcement and time-out with children), provide insight into how parents may be inadvertently reinforcing their children's problem behavior (e.g., by giving attention to negative behavior), model warmth and effective communication, and instill confidence in new and not-so-new parents alike. This type of intervention has been shown to alleviate child management problems *and* relieve depressive symptoms.²⁴

ANTIDEPRESSANT MEDICATION

It would be difficult to find a person who's never heard of antidepressant medications. These drugs have been available to depressed individuals for almost fifty years. Prozac is undoubtedly the best known, but there are many others, and they can be divided into several categories. The first includes the most commonly used antidepressants, called SSRIs. These are the "superstars" you've heard of, like Prozac, Zoloft, and Paxil. The second category are newer drugs that include Wellbutrin and Effexor. The third and fourth categories are older antidepressants, which are still considered effective but have more side effects. These comprise the tricyclics (like Anafranil and Tofranil) and the MAO inhibitors (like Nardil and Parnate).

Our society has witnessed a massive growth in antidepressant prescriptions. In 2005, antidepressants were the third most commonly prescribed medications of any kind.²⁵ Needless to say, their widespread use has provoked many strong and polarized opinions. Some argue that everyone, even relatively happy people, should be taking Prozac, while others prophesy that its widespread use will deliver terrible ills. As always, however, there is a middle ground. The fact is that 60 to 70 percent of depressed patients improve after using a single antidepressant,²⁶ although it usually takes three to six weeks for a full response.²⁷ If one drug doesn't appear to work, many depressed individuals ultimately find another one that does. On the other hand, a sizable percentage of patients do not respond well to such medications or can't tolerate the side effects. You must be careful to choose the treatment that's right for you. Someday, with the help of a new field called psychopharmacogenetics, we may be able to do this by matching the best-fitting drug to our unique genetic makeup.²⁸

The choices of antidepressants are indeed overwhelming, but a psychiatrist can help navigate the boundless information and select the type and dosage of drug that are appropriate for each case.²⁹ Indeed, each class of antidepressants is unique; particular drugs attack different brain chemicals (serotonin or norepinephrine or both), differ in their side effects, show different interactions with other medications that the patient might be

taking, and require different doses and schedules.³⁰ For example, Prozac is taken once daily, and the dosage needs to be adjusted only slightly during the course of treatment. This green pill is believed to work by increasing the amount of serotonin in the patient's brain. Its side effects are minor but include nausea, insomnia, and nervousness at the beginning of treatment; sexual side effects may be problematic throughout treatment. Another downside is that Prozac can block the effectiveness or reduce the safety of other medications (e.g., drugs taken for heart disease, migraine, or epilepsy) more so than other antidepressants in its class (such as Zoloft).

By contrast, the antidepressant Wellbutrin affects the depressed patient's levels of norepinephrine and dopamine (but *not* serotonin), so it's likely to be effective for a different sort of patient from those taking Prozac. Wellbutrin's most common side effects—insomnia, anxiety, tremor, and headache—are also different from those of Prozac, and on the positive side, it has few sexual side effects. However, its drawbacks are that it needs to be taken up to three times daily, and it has a higher chance than other antidepressants of causing seizures. Fortunately, a newer cousin of Wellbutrin, called Zyban, has addressed some of these potential problems; Zyban doesn't carry an elevated risk for seizures and needs to be taken only twice a day.

Effexor XR is yet another antidepressant, which works biologically in a different way from all the other drugs in its class. Interestingly, it raises the patient's levels of serotonin when taken in low to moderate doses and elevates norepinephrine at higher doses. Some studies show that when it comes to more severely depressed patients, Effexor XR is more effective than any other drug of its kind.

Because of their higher rates of side effects and other complications, the older classes of antidepressants are usually not used as first-line agents. However, they may be tremendously valuable for certain types of depressed persons, especially when other drugs don't initially succeed at lifting their depressions. In sum, there are many choices for pharmacological treatment of depression, and the selection process is complex, especially for the roughly one-third of depressed people for whom the first drug tried (the first-line agent) is unsuccessful. The fact that many

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options exist, however, is good news, as psychiatrists can try various approaches. The most obvious one is to switch to another antidepressant, but other options include increasing the dosage or the length of treatment, adding a second nonantidepressant drug, and giving two antidepressants simultaneously.³¹

Patients are often curious about how long they need to stay on medication and whether the depression will return once they stop. The usual recommendation is that antidepressants be taken from four to nine months (fortunately, they are not habit-forming), at which point the medication will be tapered off over one to two months. If one's depression is severe and recurrent, runs in the family, and started before age twenty, many doctors recommend maintenance treatment—that is, to continue taking the medication even after the depression has fully lifted in order to prevent recurrence. Research confirms that this is indeed good advice. In two studies the vast majority of patients who continued taking the tricyclic Tofranil for five years after experiencing depression did not have a recurrence.³² Even better news comes from studies showing that antidepressants lower the risk of future depressions even *after* they're discontinued.³³

Despite the fact that antidepressants now help millions of people, misconceptions about them are still widespread. Some claim, for example, that these drugs provide only "artificial" relief. This is the notion that depressed people need to work out their problems and deal with their depressions by themselves, without help from synthetic agents. A related assumption is that antidepressants prevent people from facing the true sources of their suffering and troubles. In response, I'd like to underscore that depression is an illness that needs treatment. Without treatment, the symptoms of depression can last for weeks, months, or even years. People with depression cannot just "snap out of it" or "pull themselves together." Hardly anyone would ever argue that people shouldn't take "artificial drugs" for cardiovascular disease or cancer or rheumatoid arthritis. It's true that depression is different—it seems to be a disorder of emotion rather than an organ of the body, like the heart or kidney—but in truth, depression is a disorder of the brain. When a drug begins to relieve the suffering of the depressed individual, only then can she begin to confront her pain.

WHICH TREATMENTS ARE DEBATABLE?

I want to mention two well-known treatments for depression that have been found to be much less effective than the ones I've already described. One is herbal therapy, the most common of which involves taking St. John's wort, a fragrant plant draped in yellow flowers in summer. In Germany many this plant is used more for depression than are conventional antidepressants, and most of the research testing its effectiveness has been done there. This work shows that it can be effective, especially for short-term periods for mild depression.³⁴ However, flaws in the studies that have been done so far prompted the U.S. National Institutes of Health to conduct a much larger and well-controlled three-year study, which found that St. John's wort was no more effective than a placebo at alleviating depression or at boosting overall functioning.³⁵ Because this herbal medicine can have dangerous interactions with other medications, and because its potency and preparation are not tightly regulated in the United States, depressed people should be vigilant when using it as a treatment.

The other treatment that has had mixed results for depression is psychodynamic therapy, which includes traditional Freudian psychoanalysis. Psychodynamic therapists believe that a depressed person's current problems can be resolved successfully only with an intense self-exploration, the goal of which is to give the person a complete understanding of her conflicted feelings and the unconscious basis of her problems in early family relationships. This type of therapy is very intensive (involving fifty-minute sessions several times a week), lengthy (usually lasting several years), and expensive. Furthermore, it has been found to be useful only for people with mild depressive symptoms or who have already improved with other treatments.³⁶

WHAT TO DO IF YOU ARE DEPRESSED

Amazingly, despite the existence of several highly effective treatments for depression, very few depressed people actually partake of them. For example, of those meeting criteria for major depression—that is, those

with the most severe symptoms and disability—only 22 percent of whites and 11 percent of Mexican-Americans receive treatment.³⁷ The percentages are undoubtedly even lower for people whose symptoms are less severe. If you suffer from depression, I strongly encourage you to try one of the immensely effective treatments that exist. The first step toward getting treatment is to make an appointment with your primary care physician. A full physical examination is necessary because many medications and illnesses (such as infections) can have symptoms that are very similar to depression, and these need to be ruled out. If they are ruled out, then the physician (or a psychiatrist or psychologist) will complete a psychological evaluation, asking you questions about the history of your symptoms, your family history, and possible substance use problems and suicidal thinking. Your speech, reasoning, and memory are likely to be tested as well; sometimes these types of abilities are affected by depressive illness. If a diagnosis of depression is made, then you and your doctor will decide on the first-line treatment.

The Cure for Unhappiness Is Happiness

The cure for unhappiness is happiness, I don't care what anyone says.

—Elizabeth McCracken

If you are deeply depressed, you may wonder and perhaps question how a book about how to become happier can help you. On one hand, you are right to be skeptical. Most people need to get a reprieve from the most troubling symptoms of their depression before they are able to muster the energy and motivation to embark on a happiness-increasing program. On the other hand, as Seligman has demonstrated, even the most severely depressed individuals can improve by doing a simple daily happiness-increasing exercise. (His study essentially involved an optimism strategy: taking time to recall three things that went well each day.) Indeed, other studies from Seligman's laboratory are demonstrating parallel results.³⁸ In one of them, researchers conducted a six-week course of so-called group

positive psychotherapy, meeting for two hours per week with eight to eleven depressed individuals at a time. Each week the participants were prompted to do a different positive exercise, such as expressing gratitude, savoring, or using their signature strengths. Compared with participants who hadn't received any treatment, the positive psychotherapy groups showed significant relief from their depressive symptoms over the course of the six-week therapy. Amazingly, their levels of happiness not only increased reliably throughout treatment but continued rising long after the intervention was over, reaching an all-time high after one year. In a subsequent study, patients diagnosed with major depression participated in a ten- to twelve-week *individual* positive psychotherapy. Patients encouraged to focus on their strengths rather than on their pathologies experienced significantly greater relief from depression compared with those receiving "treatment as usual" and even compared with those taking antidepressant medication.

The positive psychotherapy recently developed and applied by Seligman and his collaborators uses some happiness-enhancing strategies that are similar to those described in this book. In this way, their research bolsters our confidence in the value of doing happiness activities in order to positive emotions, positive thoughts, and positive experiences in order to begin to relieve mild, moderate, and even severe depression. Although the activities illustrated in Part II are not designed to "cure" depression, if you are depressed, trying one or more of these activities affords a strong chance of lightening the burden and darkness of depression *and* producing positive feelings.

Furthermore, you might consider trying one of several existing psychotherapies for depression that aim to increase well-being rather than only to relieve symptoms. These psychotherapies are relatively widely tested and established. For example, the goal of one such treatment, the short-term well-being therapy, is to improve patients' positive functioning—their sense of life purpose, positive relationships, self-acceptance, etc.—and to increase their experiences of mastery and pleasure. This therapy has been shown to be highly effective at reducing so-called residual symptoms of people who've recovered from depression.³⁹ Other promising positive-focused

therapies for depressive and other psychological disorders include Quality of Life Therapy,⁴⁰ hope therapy,⁴¹ positive psychotherapy, and personal growth therapy.⁴²

Surmounting Setbacks

A final point needs to be made. Most people experience at least one tragedy or major setback in their lives. Researchers have shown that people are remarkably resilient and, after an initial bout of misery, eventually return to their previous level of well-being.⁴³ However, while in the throes of their misfortune, some become depressed, insecure, and unable to perceive a brighter future. This type of unhappiness is temporary or reactive, and the happiness exercises described in this book may be particularly helpful at alleviating it. Committed engagement to happiness activities can lift a person out of the rut, first to a neutral point and then onto higher ground.

During the 2004 U.S. presidential campaign, vice-presidential candidate John Edwards revealed having endured the tragedy of losing his sixteen-year-old son, with whom he had been extremely close. After a period of depression and grief, he appeared to have come out of the experience a different person, with new priorities and goals. "I have learned two great lessons," Edwards wrote in his memoir, "that there will always be heartache and struggle, and that people of strong will can make a difference. One is a sad lesson; the other is inspiring. I choose to be inspired."⁴⁴ Out of depression, if we beat it, we can emerge stronger, happier, more engaged in life.

Appendix

Additional Happiness Activities That May Fit

The grid below summarizes which happiness-increasing strategies go together. Ideally, first try your four best-fitting happiness activities established for you by the Person-Activity Fit Diagnostic (see Chapter 3). After exhausting this list of four, use the grid below to help you find additional helpful happiness activities.

IF YOU BENEFIT FROM THIS ACTIVITY	YOU MAY WANT TO TRY THIS ONE	OR THIS ONE
Expressing gratitude (Happiness Activity No. 1)	Practicing acts of kindness (Happiness Activity No. 4)	Learning to forgive (Happiness Activity No. 7)