

When the Black Dog Barks: Building a Research and Theoretical Agenda for Adult Learning In and On Clinical Depression

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Everyone reading these words has probably either suffered from depression or knows someone who has. Yet the stigma surrounding mental illness means that it is rare to hear people admit to this. It is easier to hide and disguise depression than it is to hide physical disability or severe mental disorders such as schizophrenia. You can pretend to be overworked, needing more sleep, stressed, fed up, worried about your job, having difficulties in your relationship, or lonely – and people will see these as part of the ups and downs of everyday life. In my own case, I spent many years hiding depression from every human being I interacted with (including my children) other than my wife and my brothers. In this paper I wish to use my own experience of learning to understand and cope with depression as the starting point for an analysis of what might comprise a research agenda for anyone interested in exploring the adult learning dimensions of depression.

Learning how to live with, and treat, depression must be considered a massive societal adult learning task. Such a task comprises two dimensions; requiring adults to learn how to recognize, monitor and cope with such depression, and requiring adult educators to provide education about this condition. I intend to explore the first of these dimensions – how adults learn to deal with the onset of depression. In doing so I marry some prevailing paradigms in adult education to an auto-ethnography of clinical depression.

I am a well-published author in the field of adult education who has a fulfilling job, a loving family, and a rich a-vocational life focusing on soccer and music. Objectively I have absolutely nothing to be depressed about. True, I have suffered predictable life crises – the death of parents, divorce, being fired and various health problems – but by most people’s estimate I live a life of enormous privilege. For over a decade, however, I have suffered from crippling clinical depression that has overshadowed everything that I do. This depression has caused me periodically to remove myself from professional engagements (usually pleading a physical health crisis or other conflicting professional engagement as the cause) and, at its worst, has confined me to home. Many days I do not know how I will make it through the next 15 minutes without knocking myself out to ensure oblivion. At its worst I spend the day longing for evening when I can take a sleeping pill and get the 5 hours of oblivion this ensures. My barometer for measuring each day has changed dramatically from ‘what did I accomplish today?’ to ‘did I feel suicidal for most of the day?’ A day when I don’t feel suicidal these days is a gift from God, a day to treasure.

The Learning Tasks of Depression

Drawing on my own auto-ethnography, I posit that four distinctive learning tasks are required in seeking to live with depression. The first three of these have little to do with technical learning, or with understanding pharmaceutical or psychotherapeutic treatment

options. Instead, they are concerned with changes in perspective, with developing emotional intelligence, and with ideological detoxification.

1. *Overcoming Shame*

The first, and perhaps most fundamental task, is learning to live with the shame that depression induces. The feelings of worthlessness and inadequacy that accompany not being able to do the simplest daily things that were so unremarkable in the past, are debilitating, sending you spiraling down further and further into the vortex of depression. As you tell yourself for the hundredth time that day to ‘snap out of it’ – and are unable to do so - it is easy to be enveloped in self-disgust. You feel weak and helpless. It’s so clear, you tell yourself, that there’s no objective reason to be depressed. But saying this only makes the situation worse. After all, if there’s no reason to be depressed, then your inability to escape this state means you have no will power, no determination, no initiative.

Getting these feelings of weakness and shame under control were extraordinarily difficult for me. But two adult educational concepts helped me here. The first was to try to apply the critical reflection I had urged on others in writings and workshops to my own situation. I realized over time that I was trapped in two paradigmatic assumptions. A paradigmatic assumption is a framing, structuring assumption that we hold. It is so close to us, so much a part of who we are and how we view the world, that when someone points it out to us we usually deny that it’s an assumption and instead claim ‘that’s the way the world is’. Moreover, when we do start to identify and assess paradigmatic assumptions, the effect is often explosive, changing completely how we look at, and respond to, a situation. It seems to me that challenging a paradigmatic assumption warrants being considered an example of the much-invoked concept of transformative learning.

The first paradigmatic assumption I had to uncover had to do with the etiology of depression. I assumed that people feel depressed because something bad has happened to them. So the fact that depression had settled on me seemingly out of the blue was completely puzzling. Yes, 9/11 had happened a few months before, and yes, I had nursed my mother during her last weeks of cancer a year earlier, and yes, some test results had been worrying – but none of those seemed to account for the overwhelming anxiety and depression that gripped me. The paradigmatic assumption that depression was rationally caused, and therefore treated by the application of reason, took me years to unearth, challenge and discard. I had always considered myself a sentimental person, given to emotional reactions to people, compassion, sport, music and film, and had no idea of just how deeply the epistemology of European rationality was assimilated within me. Challenging and changing this assumption, so that now depression was understood to be the result of chemical imbalances in the brain, was enormously difficult. I was so fixated on my inability to reason myself out of feeling depressed that I was unable to consider any other way of understanding how depression was caused.

A major stumbling block in switching my meaning schemes here was the lack of public conversation about depression. Nobody I knew at work had mentioned being treated for

depression, there was nothing I remember reading about it in the press or seeing on TV, and I couldn't think of a single film that dealt with it, other than *About a Boy*, where a mother's depression is a minor plot thread. One result of my understanding how little public conversation there was on learning how to live with depression, was that I resolved once I began to feel more stable that I would speak publicly about my own experiences whenever possible. One must learn disclosure. One must learn to talk about this condition to one's partner, spouse, friends, parents, siblings, in-laws, children and colleagues. Somehow, in almost every speech and workshop I give these days, I try to weave in some examples of my own struggles with depression. One of the benefits of public disclosure is finding just how many others suffer from the same disease. Invariably, when I talk about learning around depression I have several people come up to me at the end of the session and tell me how much they appreciated it.

Having managed to reframe my assumptions about the etiology of depression, it became much easier to keep the debilitating effects of shame under control. If depression is linked to chemical imbalances in the brain, I could tell myself, then part of its treatment has to be pharmaceutical. Suddenly, taking drugs didn't seem a sign of weakness, an indication that I was a pathetic excuse as a human being. After all, my psychiatrist told me, you're fine with taking drugs for bodily imbalances such as high cholesterol, high blood pressure, acid reflux – why should taking drugs to redress chemical imbalances be any different?

2. Ideological Detoxification

But a second paradigmatic assumption, just as deeply embedded as my assumption that depression was rationally caused and therefore treated with reason, was also in play. This assumption was grounded in the ideology of patriarchy that had lodged itself deep within me. As an ideology patriarchy holds men to be superior reasoning beings, ruled by logic in decision-making in contrast to women, who are held to be victims of irrationality, ruled only by emotion and therefore too easily swayed by feelings to be trusted with major decisions. Now if you had asked me what I thought of patriarchy, I would have told you it was a destructive ideology, one I rejected unequivocally. But I have learned that what I think are my obvious, conscious, commitments often mask much a deeper and more enduring acceptance of dominant ideology.

I am convinced that one reason I could not shake my feeling of shame was of my uncritical acceptance of the ideology of patriarchy. "I'm a man, I'm supposed to be ruled by reason, I should be able to keep my feelings under control" was the inner voice that rumbled beneath my more conscious conversations. To take drugs to deal with a problem was something that would be OK if I was a woman, but was surely a sign of weakness for a man. So month after month, year after year, I refused to consider any suggestion of medication. This refusal was underscored by the fact that the only people I knew who were taking medication for mental problems were all women. There was no male I was aware of who was under meds for depression.

So one thing I learned about overcoming shame was that for me, a man, it required a process of ideological detoxification. I had to understand just how deeply and powerfully

the ideology of patriarchy had been implanted in me over my five decades on the planet. And I had to understand too that stopping it from determining how I thought about, and responded to, my own depression, would be a long haul. Even today, despite having written books on critical theory (Brookfield, 2004) and radicalizing learning (Brookfield and Holst, 2010) – both of which explore how to resist ideological manipulation - I still have moments when I feel there's an unseemly lack of manliness, or grit, in my suffering from and disclosing about, my depression.

3. Normalizing Despair

A third task is to learn how to normalize depression, to view it as something that is as unremarkable as possible. When you suffer from depression it's easy to conclude that you're the only one in this situation. The more isolated you feel, the more you believe that your situation is unique, that there are no supports in place for you and that there is nobody else who experiences what you experience. The sort of public disclosure I wrote about in the previous section is one counter to this. But there is another, more private, learning process to undertake that also helps to manage depression – learning how to do a realistic audit of what it is reasonable to hope for in the face of numbing dread and vulnerability.

One thing sufferers of depression learn is to take one day at a time. Instead of gauging your ability to function by whether or not you are depression-free, you learn to calibrate hour-by-hour changes. Progress is measured by how many minutes you focus on a task with your thoughts only on that task, or by whether or not your attention was distracted for periods in a sporting, or musical, event. When you're mired in depression the prospect of coming out of it seems so unreachable, so improbable, that judging your progress by how close you come to that improved state only sends you into deeper depression. You learn to adjust what is reasonable to expect to fit what is possible. For example, when I am depressed I define a great day as being one where I am not feeling suicidal.

Learning to normalize despair is, like so much of learning how to live with depression, something that involves different processes. One has to engage in social learning (learning how to use peers and fellow sufferers for emotional support and information) if you are to realize that what seems like your unique misery has generic elements embedded within it. Learning to overcome one's shame and move to self-disclosure is, as we have already seen, a major hurdle. Normalizing learning also entails maintaining hope in the face of adversity, hanging on to the belief that sometime in the future you will feel better than you do today. Such hope is like a candle flickering in the hurricane winds of dread and anxiety that sweep over you.

4. Calibrating Treatment

The study of brain chemistry is still in its infancy. One medical professional knowledgeable in this area told me that in 50 years the standard approaches we use to treat depression today will appear laughably ill-informed. But one thing that is clear is that each person's brain chemistry is different, and that each person's case therefore

requires considerable research and individual experimentation. The major part of the responsibility for this research obviously rests with the prescribing physician, whether psychiatrist or family practitioner, and also with any psychologist or therapist involved. However, the patient suffering from depression also has a role to play in monitoring how drugs or talk therapy work, the conditions under which they are most, or least, effective, what the different portions of each should be, whether the side effects (often unpleasant) of drugs are worth the distraction or relief they provide, and on and on.

The only reason I can write this chapter is because after several years of debilitating psychological torture I finally found a cocktail of drugs that keeps me intact. Doing this involved a lot of technical, trial and error sorts of learning. I had to learn how to calibrate the right mix of medication, cognitive behavioral therapy, exercise, meditation, avoidance and homeopathic remedies to find the mix that was uniquely suited to reducing my depression. I know my depression will not disappear, but through persistence and luck it is (at least, for the moment) kept at a level that is not wholly debilitating.

I have already written about some of the crucial decisions in my learning how to calibrate treatment - my decision to overcome my shame, detoxify myself from patriarchy, and normalize my despair. But, once I made the decision to seek professional help, I then had to decide what kind of help was going to be most effective. I saw three family practitioners, four psychologists and two psychiatrists in my quest to learn which combination of approaches would work for me. A major stumbling block for me was my unwillingness to change psychiatrists. I was working with a psychiatrist whose approach was one I agreed with philosophically. He believed the ultimate responsibility for treatment decisions lay squarely with the patient. So when experiencing the unpleasant side effects of anti-depressants I repeatedly would come off medications after a short period. My treating psychiatrist would respond by saying that since one treatment option wasn't working we would move to another.

My wife would often tell me that I needed a psychiatrist who would be more pro-active and unequivocal about the need for me to stay on a course of medication for more than a few weeks. I would dismiss her opinion as that of an unqualified professional, not realizing that the person who knew me best was in many ways the best person to judge what kind of psychiatric approach would be of most benefit to me. Eventually, I became so distraught that in desperation I followed her advice and managed to get an appointment with a different psychiatrist. This professional insisted I needed to get on a long-term course of medication immediately, and gave me a short-term prescription of a powerful anti-anxiety drug that would help control the worst side effects of the long term medication. As soon as we left the consulting room my wife told me he was by far a more suitable person to be overseeing my treatment, and that his directive approach was exactly what I needed.

Conclusion

What are the implications of my auto-ethnography for how adult education might engage itself with the study of depression? Several items suggest themselves to me. First, we need a greater elaboration of the learning tasks I outlined, plus all the other learning tasks

entailed by learning to recognize and cope with depression. To use Habermas' (1979) often quoted formulation, some of these will be instrumental such as calibrating doses and combinations of medicine, and practicing cognitive behavioral therapy. Some will be communicative, such as learning how to interpret medical advice from experts, or how to communicate one's situation to colleagues, peers and family members. Some will surely be emancipatory, such as challenging dominant ideology's stigmatization of medical illness. Probably, most of the learning tasks people identify will cross all three domains; after all, learning to manage medication levels leads to a liberatory feeling of self-confidence and a willingness to go public about one's own depression.

Second, the methods of learning most frequently associated with each task can be studied. Which of these involve mostly self-directed learning? Which entail learning from an authoritative teacher such as a therapist or psychiatrist? Which learning tasks are social in nature distinguished by the learner's immersion in a social network? What is the progression of methodologies? What methods most support a willingness to challenge dominant ideology? Are certain kinds of learning tasks best accomplished through particular methods, or is the personality type of the learner more important? What role do cultural factors play in disclosing and seeking treatment for depression?

Third, some of the field's prevailing theoretical paradigms can be applied to understanding depression. Coping successfully with depression is certainly an example of transformative learning, and it certainly requires an enormous amount of critical reflection. Therapists, psychiatrists and other physicians act as adult educators concerned to empower the patient to monitor and treat her own depression in a self-directed manner. From a critical theory perspective one might ask what does the stratification of depression look like? Are some groups more prone to depression, or does it escape easy location? How does the political economy of health care determine who has access to treatment? And how does professional power label some treatment options as legitimate and some as irresponsible? From a feminist perspective one might explore how women create support groups to connect their struggles to a broader network, or the degree to which learning to disclose depression is a function of gender identity. From a racialized perspective one might analyze an Africentric approach to depression, in which individual consciousness is understood always to be located in community, or a Confucian approach in which reverence for expert wisdom is the preferred approach for solving problems. In sum, clinical depression represents a major area for adult education research.

References

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