**‘The Illness That Dare Not Speak Its Name’:**

**A Narrative of Understanding Adult Learning In and On Clinical Depression**

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**Abstract**

Depression is something variously estimated to afflict between 5 and 10% of the North American adult population at any particular time. As such it represents a major community health issue. This chapter uses a narrative approach to analyze the adult learning tasks associated with dealing with depression. After situating his own experience as a sufferer from depression the author uses his own narrative to analyze four learning tasks; learning to overcome shame, learning to engage in ideological detoxification, learning to normalize despair and learning to calibrate treatment. Central to each of these tasks is the act of public disclosure. The chapter ends by suggesting directions for future research in this neglected area of adult education.

**Introduction**

The US government’s *National Institute of Mental Health* (NIMH) estimates that in any given year 14.8 million American adults (about 6.7% of the adult population) suffer from clinical depression, or major depressive disorder as it is sometimes called (NIMH, 2010). The NIMH also classifies clinical depression as the leading form of disability for Americans aged 15-44. A recent *Centers for Disease Control and Prevention* report placed the overall figure higher at 9.1%, with 4.1% suffering major clinical depression (Centers for Disease Control and Prevention, 2013). In Canada, a recent study projected the estimate of sufferers much higher than had previously been imagined, calculating that 19.7% of adults suffer from clinical depression sometime during their lifetime (Boughton, 2009).

By any calculation then depression is a major social problem that takes up an enormous number of resources and affects a staggering number of people. Yet the stigma surrounding this illness is still very strong. For example, as someone who suffers from this condition I did not know of a single male colleague or friend who admitted to being affected by this until I began to disclose my own struggles. It seemed that other men would only own up to this in conversation with me after I had publicly spoken about my own situation. Somehow, patriarchy has decreed any public admission by men of mental health problems as evidence of personal weakness.

Those who suffer from depression often blame themselves for their perceived character flaw and feel ashamed from their inability to ‘snap out of it’. Those who live with the depressed soon become exhausted by their inability to make sufferers feel better and often feel helpless to know how to respond. By any measure depression must therefore be considered a major community health problem. In this chapter I will draw on my own experience of depression to explore the interconnections between various strands of adult learning theorizing and the analysis of depression and I will propose some future directions for research in this area.

**Defining Depression**

Depression is not just feeling sad at the loss of a loved one, being devastated by a marriage break-up or experiencing a loss of identity after being fired. Neither is it feeling trapped by winter in Northern climes with the resultant lack of natural light or sun. All these things are traumatic and distressing, and any of them may trigger a depressive episode, but all are traceable to a specific root cause. In this chapter I am defining depression as the persistent feeling of complete worthlessness and hopelessness, often accompanied by the overwhelming anxiety that this hour, this day, or this week, will be your last on earth. This kind of depression has no clearly identifiable social cause such as death, divorce, or economic crisis; instead it settles on you uninvited and often completely unexpected and permeates your soul, flesh and bone.

Winston Churchill described his own depression as the black dog that prowled constantly on the edge of his consciousness. He never knew when the black dog would appear, but it became an almost constant companion – just as the presence of a dog that is a family pet is woven into the fabric of your daily life. Clinical depression is like that – quotidian, everyday, the first thing you’re aware of as you open your eyes, and the last thing you think about as you drift off to sleep (if you’re lucky enough to be able to sleep). Its very familiarity, its relentless presence, is itself terrifying, suggesting that it will always dog you (pun intended). I can speak with experiential authority about this as someone who suffers from depression and who has spent over a decade experimenting with how to function with this condition as part of my everyday life.

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 or a bi-polar condition. 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. I did so partly because I felt ashamed of my condition. I did not want my children or my friends to think of me as pitifully unable to control my life. And partly I hid this condition as best I could because I feared that public knowledge that I suffered from this would do irreparable harm to my career. In my mind I calculated that no one would trust me with any kind of professional responsibility if they knew I was struggling with this.

In this chapter I wish to use my own experience of learning to understand and cope with this condition as the starting point for an analysis of what might comprise a research agenda for anyone interested in exploring the adult learning dimensions of dealing with depression. The numbers quoted at the start of this chapter indicate that learning how to live with, and treat, depression must be considered a massive community health task. Such a task comprises two dimensions; helping adults learn how to recognize, monitor and cope with such depression, and helping adult educators to provide education about this condition. I intend to focus chiefly on the first of these dimensions – how adults learn to deal with the onset of depression, but I will also explore some aspects of the second. In doing so I marry some prevailing paradigms in adult education to an auto-ethnography of clinical depression.

**Situating Myself as a Depressive**

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 sport (soccer and cricket) 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 a sometimes 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 another 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 now changed dramatically from ‘what did I accomplish today?’ to ‘did I feel suicidal today?’ A day when I don’t feel suicidal these days is a gift from God, a day to treasure.

As I shall elaborate, I am now successfully living with depression thanks to medication that has worked to stabilize my mood. I assume I will be taking these medications for the rest of my life, though at some point I suppose I may decide to try weaning myself off them. There is still a part of me that has not come fully to terms with ‘needing’ drugs. The choice of that word ‘needing’ is itself significant, indicating as it does my sense that by taking drugs I am ‘needy’, not fully functioning, not a ‘normal’ human being. I don’t describe my taking drugs for high blood pressure or high cholesterol with the same language of ‘needing’ these drugs. I simply state my use of them as fact with no judgmental overlay as in ‘I’m taking drug A to help with high blood pressure’.

Depression seemingly came out of nowhere in my life, creeping up on me and taking me by surprise. In retrospect I can look back and see how certain events could be interpreted as pre-dating its onset. A year or two earlier I had nursed my mother through her final months of life as she was diagnosed with terminal cancer. That was obviously an experience that was emotionally exhausting and foregrounded death in the midst of my life. The September 11, 2001 attack on the World Trade Center and Pentagon also occurred just before my first major bout of depression. But saying that, I had also lived through the death of my father a decade earlier and grown used to living with IRA bomb threats in 1970’s England. Neither of these led to any major depression.

When depression took hold it was accompanied by crippling anxiety, mostly anticipatory. I would imagine that every slight twinge was incontrovertible evidence of a terminal condition I would die from in the next few months. I would assume that my friends or family being late for an appointment was because of something awful – perhaps a major accident - having happened. Every time a new disease was mentioned on TV, or a financial scandal or irregularity made the news, I interpreted that to mean that we would all contract this new virus, or that our savings had been wiped out. My dreams would regularly feature apocalyptic events such as a nuclear holocaust, tsunami or planetary implosion.

As the condition worsened I stopped sleeping or eating. I would go to bed exhausted and sleep for one to two hours and then lay awake the rest of the night. Those of you who suffer from insomnia know that the more you tell yourself you need to relax and sleep, the more impossible that becomes. I would find myself nodding off at the wheel of the car, so that driving now became dangerous. I would begin watching a soccer match and wake up when a goal was scored or at the end of the match. But sleep in a bed, during the hours I was ‘supposed’ to be asleep, deserted me.

I dropped an enormous amount of weight which itself convinced me I had an undiagnosed terminal condition and led me on an Odyssey of multiple exploratory tests, none of which revealed anything very significant. But with each test and each new indication that I did not have a particular condition I only became more convinced that what I was suffering from was so serious it was eluding all the usual tests. Then I would hear on a sitcom, on a news reports, or in an overheard remark in the coffee line, some reference to a medical condition and would seize on that as the undiscovered cause of my weight loss and demand another string of new medical tests.

As my physical appearance was changing dramatically, and my friends, family and colleagues could see something significant was going on, I steadfastly refused to acknowledge in conversation what was happening. If someone inquired after me I would say I was fine and that things were going well. I would explain that I was exercising more or was changing my diet to eat more healthily by excluding saturated fat or reducing carbs. During this period the medical professionals I interacted with would often suggest that I try anti-anxiety medicine or anti-depressants, and I would always refuse. I could not shake myself free of the belief that if I ever took drugs I was admitting that I was not in control of my life and that I was a poor excuse for a human being.

This major depression lasted at its worst for five to six years. During it I was hospitalized three times for physical collapses, twice for passing out (in my office and at an airport) and once because one of the seemingly endless battery of exploratory tests I was receiving caused the very condition – pancreatitis – that medical practitioners were investigating for! The loneliness and vulnerability a depressive feels at these times is hard to put into words. I used to imagine that I was squirming under a laser beam of pressure that I could never escape, that the eye of Mordor was fixed on me and that I was doomed never to feel at ease with the world.

At various times over these years I had flirted with the possibility of professional help and had seen a therapist about my anxiety. His excellent advice was impossible for me to follow because of the overwhelming force of the anxiety that was consuming me. I would learn the cognitive behavioral therapy (CBT) scripts I was to follow when I felt hopeless, but never had the strength to implement them. The power of reason was rendered utterly impotent in the face of the hurricane of emotions and feelings crashing over me. I thought of my dutifully rehearsed scripts as a single feeble flickering candle trying to stay alight as a force 10 hurricane smashed into it. I briefly saw a psychiatrist who suggested various different medications but after trying them for a couple of weeks I would stop them, either because they were clearly having no effect or because they were making me feel ill.

Eventually the effect of my condition on my wife was what convinced me to seek some kind of sustained medical help. I could see how frustrated she was with being unable to effect any kind of change in me and how this was causing her so much pain. One particularly bad day I raided the yellow pages and picked out every psychiatrist I could find and called them all seeking the earliest possible appointment. When that day finally came round my wife came with me and as soon as I walked into the appointment room the psychiatrist told me he was going to sign me off work because I was clearly in such a bad way. I steadfastly refused, partly because to be signed off work was a shaming public admission that I had totally lost control of my life, and partly because I was afraid of the impact this would have at my workplace. The last thing I wanted was for my colleagues at the university, and for the field as a whole, to get wind of the fact that I was suffering from such debilitating depression and anxiety.

The psychiatrist insisted I take two anti-depressant medications and prescribed a third for anxiety that I was to take for the few weeks that the anti-depressants needed to take effect. Then, to top it off, he prescribed a sleep aid to help me get more than the 90 minutes or so of sleep I had been on for so long. So now, from refusing to take any medications I was on four of them. This time I stuck with the program, helped partly by my guilt at seeing what my condition was doing to my wife, and partly by the anti-anxiety drug that really did help me weather the physical reactions of putting the anti-depressants into my system.

After about two months I started to notice a change that seemed to me totally incredible. I had completely given up on the prospect of ever feeling ‘normal’ again and had been unable to envisage a time when I would actually enjoy something ever again. Now that started to happen. I started to hear the CBT scripts that had seemed so powerless before and they helped me keep the waves of anxiety under control. I stopped viewing each day as an ordeal to get through before the relief provided by the temporary oblivion of sleep and started to look forward to things. As these things happened I would go to my regular appointments with my psychiatrist and would thank him over and over again for having prescribed me the medications he did. From resolutely disdaining anti-depressants as stupefying pleasure pills prescribed by pharmaceutical giants to make obscene profits, I became a poster boy urging that people consider these seriously.

**The Learning Tasks of Depression: Overcoming Shame**

The previous section described my own personal experience of trying to cope with depression and anxiety. In the rest of this chapter I want to draw on this auto-ethnography to break down the distinctive learning tasks that adults need to conduct as they seek 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, with ideological detoxification.

The first, and perhaps most fundamental task, is learning to counter 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. Consequently, you reason, depression is illogical and irrational with no basis in reality. But saying this to yourself 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, and no initiative. Getting these feelings of weakness and shame under control were extraordinarily difficult for me. I would not have felt compelled to try to do this had it not been for the visible effect my condition was having on my wife. But two familiar adult educational concepts helped me here – critical reflection and transformative learning.

Critical reflection is something I have written about (Brookfield, 1995) and something I am regularly asked to conduct workshops around. It focuses on helping people uncover the assumptions that frame their practice and viewing these through multiple lenses. I argue that practitioners in the human services have four lenses through which they can view their actions, decisions and judgments to ensure that these are grounded in accurate assumptions. These lenses are those of one’s own autobiography, students’, clients’ or subordinates’ eyes, colleagues’ perceptions, and the lens of theory and research. As a result of this process I argue that we come to a better understanding of power dynamics and hegemonic assumptions.

As the program of anti-depressants began to take effect I was able to start applying critical reflection 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 (Cranton and Taylor, 2010).

I often think of a paradigmatic assumption as the fulcrum or pivot that allows the lever of an assumptive cluster to operate. Start to disturb this fulcrum and the structure supported by the lever starts to crumble. To think of another analogy, a paradigmatic assumption works like a corner stone at the base of a skyscraper. Discovering that this is unsound and then trying to remove and replace it with a stronger one risks prompting the collapse of the whole building. Because paradigmatic assumptions are so foundational we usually resist examining them too hard for fear of what we might find. After all, questioning their accuracy opens up to the prospect of finding out that multiple second order decisions and judgments we have been taken rested on a false premise.

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. The cause and effect relationship was clear to me. You suffer a traumatic event such as being fired, separating from a partner, having someone you love die, finding out you have a serious illness or being betrayed by a trusted friend and you are plunged into despair. Over time the hurt and despair fade as you find new work, build new relationships, and accept death or illness. In this model depression has an identifiable trigger event, a specific critical moment that shatters your world and leaves you feeling confused and hopeless.

So the fact that depression had settled on me with no specific trigger event, that it had sneaked up 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 with the assumption that depression was as much 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. Two female friends – both in adult education - had spoken to me about their own use of anti-anxiety drugs and anti-depressants, but not a single male. As I shall argue later in this chapter, the patriarchal notion that women because they are weaker creatures will need drugs but that ‘real’ men don’t take them was very present in me, even if it was unarticulated. There was nothing I could remember reading about dealing with depression in the press 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 and the comedy *Analyze This* where Robert De Niro plays a broad caricature of his character in *Goodfellas*. True, Tony Soprano in the wildly popular *The Sopranos* HBO TV series was being treated for depression, but this hardly seemed to immobilize him. He maintained and increased his power in the mob, eliminated rivals, slept with multiple women who found him irresistible or whom he intimidated, and generally seemed to thrive. And he did all this whilst resolutely keeping his condition private for fear of the effect this would have on his authority.

What I needed were examples of men who were struggling with depression but who clearly suffered as a result and hung on to their image of being successful while others around them could see the debilitating effect was happening. Tony Soprano had panic attacks but he certainly didn’t lose weight. And although he had bouts of insomnia these did not seem to reduce his powers of resolve or adversely affect his energy levels as he built his empire or intimidated his peers.

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. I remember the first time I did this at a major event when I delivered the keynote speech to the annual conference of the American Association for Adult and Continuing Education, the major professional adult education body in North American adult education. I regarded this as in informed act of adult education. I was taking the chance to raise this issue and deliberately to personalize it by opening up about my own struggles with it. In preparing to do this I asked myself a lot of questions; is doing this self-aggrandizing or self-indulgent, and am I presenting a false narrative of heroic redemption? I guess that the answer to that question probably lies in other people’s judgments and that I am too close to the act I am describing to have a clear perception of it.

Again, I emphasize that making this disclosure was an adult educational act based on my analysis of learning to overcome shame. 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 appropriate examples of my own struggles with depression. Since I’m often asked to speak about adult learning or about how to help people think critically it is very easy for me to speak about learning to question assumptions I had about depression as I try to illustrate some general themes. 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. This has emboldened me even more to make sure that I use autobiographical disclosure to bring depression into the open. And when I do this I always explain my rationale for doing this, referencing my lack of any male examples of apparently successful depressives owning up to the difficulties of living with this condition.

Having managed to reframe my paradigmatic 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. I started to notice slogans like the one on the side of a building at the intersection of 72nd Street and Broadway in New York to the effect that depression is not a personality flaw but an imbalance in brain chemistry. Suddenly, 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 brain based chemical imbalances be any different?

I don’t want to present this narrative as one of a triumphal slaying of the ideological demons of patriarchy in which I emerge as a fully centered human being entirely at ease with myself. Part of me still speaks the script of personal weakness as I hear the inner voice telling me how sad it is that I should need pills to prop me up as I make my way through the day, and how millions of people – especially men – have had to deal with this in human history with no pharmaceutical aids. One part of me knows that this is a voice I must resist hearing, that it is a false, lying voice that represents the ideology of patriarchy; but that does not mean I am totally immune to its siren call. Just as I will never be free of racist impulses and instincts learned from decades of socialization into the ideology of White supremacy, so patriarchy still has its hooks in me.

I want to examine the ideological dimension to learning about depression in the next section but before I do so I want to make one final point about the importance of public narrative disclosure. To my surprise my realization of the powerful effects my narrative descriptions of my own depression were sometimes having led to a major shift in my work as a doctoral dissertation advisor. I can hardly think of anything more removed from the emotional turbulence of dealing with depression than the very heady work of helping students conceptualize dissertation problems. Formulate a study’s question, drafting appropriate methodologies for investigating that problem or question, and determining which elements of relevant literature need to be included in a review of salient research seem to be resolutely abstract processes.

However, since ‘coming out’ with my narrative as a depressive I have become more and more interested in the work done by Robert Nash and his colleagues on a form of doctoral dissertation they call a *Scholarly Personal Narrative* or SPN (Nash, 2004; Nash and Bradley, 2011; Nash and Viray, 2013). An SPN places the writer’s narrative of her experience as the content of the dissertation. The writer tells a story that she feels is rich with insight, and that can illuminate the complex dynamics behind the particular case studied. The typical narratives SPN’s document are activist attempts to fix a broken humanity. Although SPN’s do deal with the kinds of technical problems emphasized by the Carnegie Academy on the Scholarship of Teaching and Learning, these are always understood within the writer’s broader story of civic and personal transformation.

Two specific elements make an SPN an example of scholarship. The first is the frequent use of research and theoretical literature to illuminate the particularities of the narrative, to amplify and critique, and to offer multiple interpretations, many of which are not embedded in the writer’s own telling of the story. So an SPN moves back and forth between individual narrative exposition and theoretical commentary. The second is the continuous attempt to theorize generalizable elements of particular events, contradictions and actions. The particular events in a narrative may be unique to the individual but they often contain universal elements.

It has taken seeing the effect of my own disclosure of struggling with depression to realize that narrative is one of the most compelling pedagogic approaches I can use. Nothing draws people more quickly into considering information and perspectives that are challenging than a personal story, and dissertations that are scholarly personal narratives are, I believe, often far more likely to influence practice than third person research reports. As a professor I now teach about the methodology of SPN’s and encourage students to think of writing such a document for their dissertation. Many are reluctant, citing its apparently unscholarly character, or being reluctant to put their own experience up for public view. I understand both these reservations but have put my own institutional political capital behind this option for writing a dissertation. I know that I would never have been so persuaded by the importance of personal narrative had I not deliberately used this own approach in my efforts to talk publicly about depression.

**The Learning Tasks of Depression - Ideological Detoxification**

I use the phrase ideological detoxification to describe the learning involved when we make a deliberate attempt to uncover how elements of dominant ideologies such as White supremacy and patriarchy are reflected in the minutiae of daily decisions, judgments and actions. To understand how this kind of learning happens I need to say something about the concept of ideology itself. Of all the ideas associated with critical theory the notion of ideology is the most important. Ideology – sometimes labeled ‘dominant ideology’ - comprises the set of broadly accepted beliefs and practices that frame how people make sense of their experiences and live their lives. When it works effectively it ensures that an unequal, racist and sexist society is able to reproduce itself with minimal opposition. Its chief function is to convince people that the world is organized the way it is for the best of all reasons and that society works in the best interests of all.

Put colloquially, ideology is present when we shrug our shoulders in the face of misfortune and say “that’s life”. When I was growing up in England a popular phrase was “mustn’t grumble”. This was sometimes said in response to all manner of inconveniences, setbacks and difficulties. “Mustn’t grumble” was the universal salve to ease the pain of illness, unemployment, rising prices, falling wages, food shortages, power cuts, IRA bombings, unemployment, lack of access to decent health care, strikes, and the overall realization that life wasn’t going to get any better. When people really believe that they “mustn’t grumble” then the system is safe. Grumbling, on the other hand, challenges the system. If enough people grumble they might start to hear each other making the low rumbling sound of protest and decide to seek each other out to do something about a situation. If “mustn’t grumble” is ideology in action then “must grumble” is the start of ideology critique.

Ideology is hard to detect being embedded in language, social habits and cultural forms that combine to shape the way we think about the world. It appears as commonsense, as a given, rather than as a set of beliefs that are deliberately skewed to support the interests of a powerful minority. As Fromm (1968) puts it, “ideologies are ready-made thought-commodities spread by the press, the orators, the ideologists in order to manipulate the mass of people for purposes which have nothing to do with the ideology, and are very often exactly the opposite” (p. 153). Understanding this process - how ideology works to support the power of a minority while appearing to advance the interests of all - is one of the central ideas in Marx and Engels’ *The German Ideology* (1970). They write “the ideas of the ruling class are in every epoch the ruling ideas: i.e. the class which is the ruling material force of society is at the same time its ruling intellectual force … the class which has the means of material production at its disposal, has control at the same time over the means of mental production” (p**.** 64). The individuals comprising this ruling class exercise dominion not just over the production and distribution of material goods but also over the ways people think. In recent years post-structuralists such as Foucault (1980) have clarified how knowledge and power entwine to create regimes of truth – dominant ideas, frameworks of analysis and forms of discourse that shape how we think about the world.

So what kind of ideology did I need to learn to detect and challenge in my attempt to understand how to live with depression? And what kinds of assumptions about depression were in fact ideological? I believe that 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 that patriarchy – the ideology that holds men to be superior reasoning beings, ruled by logic in decision-making (as against women, who are held to be victims of irrationality, ruled only by emotion) – was a legitimate view of the world. 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. I would have said that it represented a ridiculously bifurcated and essentialist view of life, and that this view was one that was empirically disproved for me every day I was on the planet. 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, and a reason why I refused any medications for so long, was because 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 already mentioned that the only people I knew who were taking medication for mental problems were all women. There was no male I was aware of 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 six decades on the planet. I still hear myself in marital arguments saying to my wife “when you’ve calmed down I’ll be happy to talk about this”. I laugh at sexist jokes and caricatures and my early understanding that men shouldn’t suffer from depression but that it’s fine for women to manifest it has not entirely disappeared. This signifies that I am clearly still in thrall to sexist stereotypes of what makes men and women different. So engaging in ideological detoxification is not something you do once and then consider the project to be completed. It’s not something you earn a diploma or certificate in that licenses you to help others in that endeavor. It’s a long haul and a journey where the end is never reached

Knowing the difficulty of countering ideological manipulation meant that 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 feel there’s an unseemly lack of manliness, or grit, in my suffering from and disclosing about, my depression. One thing that has been helpful in my attempts to detoxify has been receiving comments from men about how my disclosure has been helpful to them. So now, whether I’m in a major corporation or the Marine Corps, I try to seize the opportunity to illustrate how critical thinking happens by use my own attempt to analyze the ideologically determined assumptions I had about depression.

**The Learning Tasks of Depression: Normalizing Despair**

Normalizing despair may seem a strange learning task to identify. Isn’t the whole point about depression that we wish to stop it being such a given that dominates what we consider to be a normal way of living? Well, yes, that’s what we would hope would happen. But part of learning to counter depression is first of all learning to view it as something that is as unremarkable as possible. By normalizing depression I mean learning to see it as something that many people suffer from, even if few make that fact public, so that understanding that you suffer from this does not lead you to conclude that you are singularly alone.

When you suffer from depression it’s easy to conclude that you’re the only one in this situation. After all, if you don’t know anyone in your immediate circle who is dealing with this the obvious conclusion is that nobody has any idea what you’re going through.

The fact that your non-disclosure of your condition might also be present in other people’s lives never seems to occur to you, or at least it didn’t to me. 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 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. To use an analogy already quoted in this chapter, such hope is like a candle flickering in the hurricane winds of dread and anxiety that sweep over you.

One of the greatest blockages to living with depression is to have an unrealistic sense of what is possible. You will not come out of depression in a dramatic way, you won’t wake up one day and suddenly find it’s disappeared. Instead, you need to learn to set small goals and find a measure of satisfaction in achieving them. Although I am an advocate of medication one of the worst mistakes is to believe that by simply taking a pill your mood will magically change and everything will be fine again. Even when things have eventually righted themselves there will still be the rumblings of depressive tendencies beneath your surface contentment. These manifest themselves for me in repeated dreams where the same disastrous scenarios play themselves out over and over again. Also, at times of stress, I feel the familiar anxiety driven scripts shouting out loudly in my head. The difference medication makes is allowing CBT techniques to counter such scripts and keep me relatively calm.

I often make what some may think is a rather bizarre connection between learning to have a realistic sense of what can be achieved when dealing with depression and evaluating teaching. One of the things that I am still trying to learn is to have a realistic sense of what might be achievable in a particular teaching context. I still have trouble letting go of the ‘teacher as hero’ narrative where somehow, by calling on my uniquely charismatic or empathetic powers, I banish student resistance to learning and galvanize the most stubbornly reluctant learners into becoming enthusiastic advocates for whatever learning I am urging on them. If I leave a class with some students clearly feeling confused or expressing doubt about the validity of knowledge or skills I am asking them to engage with, I feel my essential worth as a teacher is called into doubt.

As my co-teachers often point out to me, however, many good things happen in classes where I leave feeling flat or disappointed. My co-teachers also point out the depth of student resistance to learning and the reasons why I have very little control over that. Just as I struggle to keep perspective on how I define good teaching or what counts as a good class, so I struggle with what I can realistically expect on a day when I am trying to keep my depression in some sort of perspective. I need to hear from other sufferers about what counts for them as small steps of progress and what a good day looks like.

**The Learning Tasks of Depression -** **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 will appear laughably ill-informed. But one thing that is clear is that each person’s brain chemistry is different, and that if medications are involved then 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 never totally disappear, but through persistence and luck it is (at least, for the moment) kept at a level that is not 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 had early intermittent contact 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. There would be no pressure to stick with the program and no sense of shame or disappointment when I didn’t. As a result I loved working with this person despite my condition showing no improvement.

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, as I mentioned earlier, I became so distraught at her frustration and pain in being unable to help me 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.

It was striking to me that as someone who had spent his career writing, speaking and doing adult education I had so little insight into what approach would best foster my own learning about depression. I was so convinced of the validity of my analysis of who would be best suited to treating me that I never sought to question it. By the way, I still believe in the validity of my conception of how good psychiatrist or educator should work. As a dissertation advisor I don’t prod my students to finish, I don’t threaten them with dire consequences if they don’t get something to me when they say they will. Instead, I assume that they are adults in control of their own lives and should be treated as such. When they are ready to send something to me they will, but that must be their decision.

The trouble with this approach is that it works well with students who are well grounded in the area of their research, who know a lot about the different options facing them as they make methodological choices, and who are good at time management and are self-motivated. But for students who are novices, who are feeling overwhelmed by the new knowledge area in which they are immersing themselves, who are insecure about their academic capabilities or who are procrastinators, this approach can be exactly the opposite of what they need. In just the same way, my preference for a psychiatrist who didn’t push me and didn’t blame me for coming off medication early, meant I always took what looked like the ‘easy’ or ‘manly’ option of not taking medications. I lacked the self-awareness and the knowledge of the pathology of depression to be able to choose what kind of psychiatrist would work best for me.

**Future Research Directions**

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, 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 could certainly be argued to be 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? For example, the CDC report quoted at the outset of this chapter reports that some of the groups who are most likely to meet the criteria for suffering from major depression are racial minorities, those who dropped out of high school, the unemployed and those without health coverage (Centers for Disease Control and Prevention, 2013).

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. As argued in this chapter, men are far less likely to go public with their struggles in this area. 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. Should a different approach be taken in creating programs to teach about living with depression for students from a particular racial or cultural background?

It will also be necessary to examine the pedagogic techniques that work best in this area. I have already suggested two complementary approaches – regular narrative disclosure of personal struggles by teachers with their own depression, and team-teaching. But what does this mean for those who do not suffer from depression as we can assume is the case with many medical practitioners? Does the fact that they do not deal with this disqualify them from educating others about it? That seems a ridiculous conclusion to draw. We do not require oncologists to be cancer survivors or nutritionists to be overweight. But at some point I would argue that real world narratives of dealing with depression be used as the central teaching resources.

In sum, helping people who suffer from this condition learn about their depression is a major community health task. And, given that many sufferers live with spouses, partners and friends, and work with colleagues, who are desperate to help another dimension of adult education needs to concern itself with teaching those people how best to support the person struggling with depression. As the stigma of mental illness recedes we can only hope that the efforts to educate about it will grow more vigorous and sophisticated.

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**KEY WORDS & DEFINITIONS**

*Depression* - a persistent feeling of complete worthlessness and hopelessness, often accompanied by the overwhelming anxiety that this hour, this day, or this week, will be your last on earth

*Adult learning* – the process by which adults learn to understand depression as a problem of brain chemistry rather than a personality flaw

*Adult education* – the planned fostering of learning about depression that includes program design, pedagogy and evaluation of learning

*Critical reflection* – the intentional attempt to uncover assumptions that guide actions by viewing one’s practice through the lenses of autobiographical experience, students’ eyes, colleagues’ perceptions and theory

*Etiology* – the medical causation of a particular condition, in this case depression

*Paradigmatic assumption* – an assumption that is so foundational that it is particularly hard to uncover and even harder to challenge

*Disclosure* – the methodology of using narrative disclosure of a teacher’s own struggles with depression as a teaching approach

*Scholarly Personal Narrative* – a form of dissertation that centers the personal narrative of the writer but that moves in and out of theoretical reflection