Perspectives on Depression:
Helping Holistic Professionals Understand Depression and Support Healing

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Abstract

Depression: It is something that most people experience at least once in their lifetime, and something that holistic health professionals are likely to encounter often in the course of working with people. Since the early 20th century, depression has increasingly been defined as a disease and confined to treatment within a biomedical paradigm. Despite this trend, often, depression sufferers will seek out holistic health professionals for information and support in addition to, or even in lieu of, biomedical therapy. While holistic health professionals neither can, nor should, be expected to possess the expertise necessary to diagnose or treat depression, there is much that they can do to support individuals who are experiencing depression in ways that both honor the process and support self-healing in the individual. This paper describes a framework that is designed to help all holistic health professionals understand the interconnected nature of depression from three perspectives—from the outside in, from the inside out, and from the perspective of energy—so that they can work with depression more holistically and effectively. The framework uses integral theory as a foundation for understanding the inside-out and outside-in perspectives; it also draws insight from nonlinear dynamic systems theory to explore how depressed energy may become impeded or stuck, and how to gently get it flowing again.
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Perspectives on Depression: Helping Holistic Professionals Understand Depression and Support Healing

Depression: It’s an experience that almost everyone encounters at least once in his or her lifetime, and that significant numbers of people encounter multiple times. Normally considered the special purview of psychology, psychiatry, and medicine, depression is not a subject that is commonly addressed in the field of holistic health education. It should be, however, for at least three reasons. First, those who are educated in the principles of holistic health have access to an array of bodymind research and other information for understanding how depression relates to the whole person, and not just particular aspects of the person such as mood or brain function. Second, more and more people are yearning for solutions to their problems that extend beyond the analyst’s couch or the doctor’s prescription pad, and are seeking help from outside of mainstream medicine. An improved understanding of depression by holistic health professionals will help to insure that these people receive information and support that is truly holistic and not simply alternative. Third, a holistic understanding of depression can help holistic health professionals to better work with depression when it arises in themselves. A small survey of 14 holistic health education students and professionals was conducted for this project, and all respondents reported experiencing depression at least one time in their own lives. Nearly three-quarters reported experiencing mild depression three or more times and 62% reported experiencing major depression at least once in their lifetime.

The most effective teachers, healers and leaders tend to be those who have firsthand experience with their subject. This means that holistic health professionals who have both experienced depression personally and learned about it from a holistic perspective may be the best prepared to assist others on their healing journey, while those who do not have firsthand
experience will need other ways to obtain the additional perspectives needed. It is both of these groups of people for whom the Perspectives on Depression framework was developed. The framework enables all holistic health professionals to understand the interconnected nature of depression from three perspectives—from the outside in, from the inside out, and from the perspective of energy—so that they can work with depression more holistically and effectively. The framework uses integral theory as a foundation for understanding the inside-out and outside-in perspectives, and also draws insight from nonlinear dynamic systems theory to explore how depressed energy may become impeded, and how to gently get it flowing again.

This paper is divided into three parts. The first part briefly explains how depression is understood and experienced in America. It further distinguishes biomedical and holistic perspectives on depression, and clarifies why a holistic framework for understanding and working with depression is needed. The second part builds a foundation for the proposed framework by positioning depression within a context of holistic philosophy and integral theory. This part also questions the “depression as disease” paradigm and distinguishes between “normal” depression that can lead to self-healing and “major” depression that has become stuck and, therefore, no longer serves a healthy purpose. The third part presents the Perspectives on Depression framework, with the ultimate goal being to help holistic health professionals better understand and support people who are experiencing depression.

**Depression in America**

Depression is considered to be the most widespread mental disorder of modern times (Teodorescu, 2003, p. 100). Although primarily categorized as a “disorder of mood,” the symptoms of depression permeate multiple aspects of a person’s life, encompassing the cognitive, emotional, motivational, and physical realms (p. 102). The Diagnostic and Statistical
Manual of Mental Disorders 4th ed., text rev. (DSM-IV-TR) classifies major depressive disorder (MDD) as including five or more of the following symptoms that persist for most of the day, nearly every day, for at least two weeks: (1) depressed mood, or loss of interest or pleasure; (2) diminished interest in most or all activities; (3) significant weight loss or weight gain; (4) decrease or increase in appetite; (5) insomnia or hypersomnia; (6) observable psychomotor agitation or retardation; (7) fatigue or loss of energy; (8) feelings of worthlessness, or excessive or inappropriate guilt; (9) diminished ability to think or concentrate, or indecisiveness; (10) recurrent thoughts of death, suicidal thoughts with or without a specific plan, or suicide attempt (American Psychiatric Association [APA], 2000a). These symptoms must not be directly attributable to drug or medication use, an existing medical condition, or acute grief (para. 1). MDD is further classified according to severity (mild, moderate, or severe), depending on the degree to which symptoms interfere with social or occupational functioning (APA, 2000b, paras. 3-5).

According to the most highly validated estimates, more than 30 million American adults (about 16.6%) will experience a major depressive episode at least once in their lifetime, and 12-month prevalence of MDD has been reported to be 6.6% (Kessler & Wang, 2009, p. 6). Although men are only about half as likely as women are to experience MDD in their lifetime—12.7% among men versus 21.3% among women (Nolen-Hoeksema & Hilt, 2009, p. 386) —it is possible that men experience depression far more often than what is reported, but that they either do not acknowledge their feelings, or they express them in different ways (e.g. self medicating) (Zeuss, 1998, pp. 69-70).

In addition to MDD, up to 20% of adults and 50% of children surveyed have reported experiencing symptoms of depression during the previous seven days to six months (Kessler &
Wang, 2009, p. 6), indicating that depression often either goes undiagnosed, or it is not severe enough to be classified as MDD. There are also many people who experience depression-like symptoms, but who may not identify themselves as being depressed. For example, because concepts of depression vary across cultures, many non-Western sufferers tend to report symptoms more in physical, or somatic, terms than in psychological terms (Chentsova-Dutton & Tsai, 2009). This holds true for non-Western immigrants to the United States, regardless of acculturation levels (p. 370). Cultural beliefs about depression that differ from Western biomedical concepts, therefore, may prevent some sufferers from identifying depression and seeking help (Feely, Sines, & Long, 2007, p. 399).

Another reason that depression may not be readily identified is because sufferers often live for extended periods of time not knowing what is “wrong” with them (Feely et al., 2007, p. 398). These people may initially attempt to deal with the depression on their own, seeking to understand their experience based on their own beliefs and frames of reference. Feelings of helplessness and hopelessness, indecision, and personal and social barriers must first be overcome before external help is sought (p. 399).

However depression is described or defined, it is common and often quite debilitating. Research indicates that depressed individuals experience functional impairment at least as great as those with illnesses such as lung disease, diabetes, or cancer (Segal, Williams, & Teasdale, 2002). Further, the experience of depression cuts across lifespan, gender, and social class (Westgate, 1996, p. 26) such that the World Health Organization (2012) has characterized it as the “single most burdensome chronic condition in the world in terms of total disability-adjusted life years among people in the middle years of life” (as reported in Kessler & Wang, 2009, p. 12.) The framework that will be presented here encompasses all forms of depression, including
all of its subtypes and degrees of severity, except for bipolar depression (which involves the alternation of depression with mania) and the transient episodes of normal grief that accompany losses, such as the loss of a job, a relationship, or a loved one.

**Biomedical and Holistic Perspectives on Depression**

Since the beginning of the 20th century, depression has increasingly been viewed as arising primarily out of biological processes, and much attention has been focused on discovering and controlling its underlying biological mechanisms. Today, even mainstream psychology is focusing more and more on biological aspects of depression, such as neurotransmitters and antidepressant medications (Feely et al., 2007, p. 393; Granahan, 2005, p. iii). Even within the realms of psychology and biology, depression is an extremely complex issue, with more than 27 theories of depression, 99 identified factors that contribute to its onset and maintenance, antidepressant drugs numbering in excess of two dozen, and at least 200 existing psychotherapies (Teodorescu, 2003, pp. 100, 103).

Despite the increasing subsumption of depression within a biomedical paradigm, over the past few decades, converging research from multiple disciplines also has led to a greatly improved understanding of the multidimensional, interconnected, and indivisible nature of human experience and behavior, or what Read and Stoll (2010) termed “bodymind gestaltic processes” (p. 147). Viewed within this emerging, holistic paradigm, depression is not defined as a disease of the brain, but as a whole-person experience involving emotional, physical, cognitive, social and spiritual dimensions of being (Moore & McLaughlin, 2003, p. 46; Westgate, 1996, p. 75).

**Holistic Help Wanted**

Many times, depression sufferers will seek out holistic health professionals for
information and support in addition to, or even in lieu of, biomedical therapy. While only about 12% of depressed people actually see a mental health specialist for their problem (Segal et al., 2002, p. 11), in a national survey, 53.6% of people with severe depression reported using complementary and alternative therapies for treatment of their depression during the previous year (Kessler et al., 2001, p. 289). This is an indication that, in the course of their work, holistic health professionals—educators, coaches, nutritionists, somatic workers, and others—are highly likely to encounter many people who are experiencing depression. Furthermore, many of these people may be attempting to self-treat their depression instead of seeking conventional treatment.

While holistic health professionals neither can, nor should, be expected to possess the expertise necessary to diagnose or treat depression, there is much that they can do to support individuals who are experiencing depression in ways that both honor the process and support self-healing in the individual. And many holistic health professionals are interested in learning how to do this, as indicated by the previously mentioned small survey. When asked if they would like to learn more about how to work holistically with depression, 100% said yes.

It is this author’s contention that the holistic health professionals who will be best suited to working with depressed individuals are those who (1) hold to a truly holistic philosophy, (2) have developed a holistic understanding of depression from multiple perspectives, and (3) are committed to being fully present on the journey, bringing the whole range of their holistic knowledge and skills to bear in order to meet depressed individuals where they are. Each of these concepts will be discussed in more detail later. For now, the primary question is: How are holistic health professionals to acquire the philosophy, understanding, and discernment needed to support people with depression? Unfortunately, while the literature on depression is voluminous, only a minority of it approaches depression from a holistic viewpoint. Moreover, much of the
literature that does contain holistic underpinnings is geared to psychology professionals specifically, and not to holistic health professionals in general (e.g. the writings of Granahan, 2005; Lask, 2011; Teodorescu, 2003; and others).

What is needed is a framework that holistic health professionals can use to understand the interconnected nature of depression from multiple perspectives, and through which they can support depressed individuals on their healing journey. A holistic framework for understanding and working with depression that is based on integral theory and energy concepts will be the main focus of the latter portion of this paper; but in order facilitate understanding of the framework, a bit of a foundation must first be laid. This foundation includes a description of holistic philosophy as it is meant in this context, as well as the basic application of integral theory to create a map for visualizing aspects of depression from both biomedical and holistic viewpoints. Later, the framework for the holistic view of depression will be expanded to include three perspectives: an inside-out perspective, an outside-in perspective, and an energy systems perspective. Although it may sound complicated, the ultimate goal of this framework is to provide, as much as possible, a clear and simple means of understanding depression and supporting self-healing.

Laying the Foundation: Holistic Philosophy and Integral Theory

Holistic Philosophy

A holistic philosophy of health, as the concept is employed here, refers to the belief that illness, healing, and health all occur within the context of the whole person—mind, body, spirit, community and environment—not just within one aspect or another. In summary, based on the ideas of Robison and Carrier (2004), holistic health professionals who hold this philosophy are able to: (1) believe that individuals are intrinsically whole; (2) view health as the manifestation
of complex connections between interrelated spheres; (3) understand that illness is a result of both internal and external struggles and imbalances; (4) recognize that these struggles and imbalances come with meaning embedded in them; and (5) hold that all healing arises from within. Furthermore, without a holistic philosophy, one’s approach to health may be alternative or eclectic, but it is not truly holistic (Robison & Carrier, 2004, p. 69).

**Integral Theory**

Integral theory provides perhaps the most comprehensive means of conceptualizing holism (Figure 1). At its most basic level, integral theory offers us a four-quadrant map that allows us to visualize the four fundamental perspectives or “4 basic ways of looking at anything” (Wilber, 2006, p. 20). If the “anything” we are looking at is the individual, then the upper left (UL) quadrant represents the “I” perspective (the inner view of the individual), which includes one’s self and consciousness. The upper right (UR) quadrant represents the “IT” perspective (the outer view of the individual), which includes observable and measurable things having to do with one’s brain and organism. The lower left (LL) quadrant represents the “WE” perspective (the inner view of the collective), which includes phenomena that the individual creates and shares with other individuals in the collective, such as culture and worldviews. Finally, the lower right (LR) quadrant represents the “ITS” perspective (the outer view of the collective), which includes observable and measurable things such as the social systems and environment in which one is embedded (p. 22). (For a more complete discussion of the quadrants of integral theory, see Wilber, 2006). Although we tend to speak of them individually, according to integral theory, these four perspectives are simultaneously present everywhere, at all times, and in everything.
Since the early 20th century, depression has increasingly been defined as a disease and confined to treatment within a biomedical paradigm (Granahan, 2005, pp. 3-4; Leventhal & Martell, 2006, p. 21). This trend has been strengthened, if not directly driven, by the way depression has been classified in the DSM. According to Leventhal and Martell (2006), versions of the DSM published since 1980 (DSM-III through DSM-IV-TR) include biological assumptions that reduce the etiology of all mental disorders to biological phenomena (pp. 18, 22). Those who

**Figure 1.** The four quadrants of human experience (adapted from Wilber, 2006, p. 22).

**Integral Maps for Understanding Depression: Biomedical and Holistic Perspectives**

Since the early 20th century, depression has increasingly been defined as a disease and confined to treatment within a biomedical paradigm (Granahan, 2005, pp. 3-4; Leventhal & Martell, 2006, p. 21). This trend has been strengthened, if not directly driven, by the way depression has been classified in the DSM. According to Leventhal and Martell (2006), versions of the DSM published since 1980 (DSM-III through DSM-IV-TR) include biological assumptions that reduce the etiology of all mental disorders to biological phenomena (pp. 18, 22). Those who
hold to this disease-oriented paradigm look for underlying biological pathologies—such as faulty brain chemistry—to explain depression and other “mental disorders,” and then treat them with therapies and drugs aimed almost exclusively at the upper right quadrant (Dacher, 2006, p. 37).

**An integral map of the impact of a biomedical perspective of depression.** While it is true that the UR quadrant is the primary target of the biomedical arsenal, to an integrally informed observer, the impact of the biomedical view of depression reverberates in all of the quadrants (Figure 2). For example, consider an individual who is diagnosed with major depressive disorder according to the *DSM-IV-TR*. Because it is one of only two diagnostic systems accepted for clinical use in the United States (the other is the *International Classification of Diseases*), we can reasonably locate the *DSM* in the LR (social system) quadrant. Further, since a clinical diagnosis of depression will go into a person’s medical record, the American health care system can also be found in this quadrant. The same thing applies to insurance companies, which only cover treatment expenses if an illness is diagnosed according to clinical guidelines. This means no diagnosis, no payment. (It is ironic that the same diagnosis will also likely impair an individual’s ability to obtain medical insurance in the future.) Finally, one cannot fail to include in the LR quadrant pharmaceutical companies, which sponsor much of the research on depression, and legally use aggressive marketing tactics to sell antidepressant medications to the public.
More than people generally realize, a biomedical view of depression also deeply influences cultural perceptions in the LL (cultural) quadrant. With a pill for virtually everything, and in a culture that deifies positivity and productivity and detests pain, society tends not to tolerate depression, except for a reasonable period of grieving after loss (Granahan, 2005, pp. 5, 10; Rosen, 1993, p. 5). Buying into these cultural beliefs leads many people who experience depression to hide, suppress, deny, or quietly medicate it, all the while striving to “put on a

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happy face” in order to be socially acceptable. Many in the psychological community, as well, have succumbed to the notion that their primary role is to “take away the pain” and fix people as soon as possible using medications and behavior management therapies (Granahan, 2005, p. 15). When added to the stigma that society still attaches to emotional problems, biological explanations for depression become appealing precisely because they help to reduce social stigma and increase hope that redemption can be found in a pill (Leventhal & Martell, 2006, pp. 28-29).

It is largely based upon the beliefs and values absorbed from our culture that we develop our internal sense of self, which manifests in the UL (self) quadrant. This self-sense, too, is subject to the influence of a biomedical view of depression. This certainly was true in Granahan’s (2005) experience, where defining mental health issues as a biological illnesses caused by chemical imbalances led many of her clients to define themselves as being “diseased, defective, dispensable, depressed, and dependent on drugs” (pp. 2-3). Rosen (1998) also noted the effect of societal influences on the individual’s internal experience of depression, stating: “Thus, depressed people, subtly pressured by their culture to think of themselves as sick and possibly even evil, do not give themselves time and space to understand their depression…they are too ashamed or concerned with denying it, hiding it, or bemoaning it” (p. 5). And so we come full circle, with a biomedical perspective on depression impacting every quadrant of one’s experience.

**Critique of the biomedical perspective.** One of the primary criticisms that can be made of a biomedical perspective on depression is that it leads to the widespread belief that taking drugs is necessary and beneficial. The use of antidepressant medications nearly doubled in the U.S. between 1996 and 2005; by this time, about 10% of Americans 12 years and older, or 27
million people, were using them (Olfson & Marcus, 2009, p. 848). This increase in medication use is at least partially due to the billions of dollars that pharmaceutical companies spend annually to market their products to physicians and consumers, sponsor continuing medical education, and fund research (Leventhal & Martell, 2006, pp. 40-48). Further, nearly all of the studies that are published on antidepressant efficacy are positive. For example, when reviewers compared a group of 74 published and unpublished studies, they found that all but one of the positive studies (37 out of 38) were published (Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Of the remaining 36 studies that were either negative (24) or questionable (12), 22 of them were never published, and 11 were published as positive (pg. 252). Careful analysis of efficacy measures has led some authors to conclude that the actual benefits of antidepressant drugs are only slightly greater than placebo (Gordon, 2008, p. 22; Leventhal & Martell, 2006, p. xiv). In addition, any effect medication does have is to suppress symptoms; it is not a cure for depression (Segal et al., 2002, p. 17). This means that, when the medication stops, so does its effect.

A second criticism of the biomedical perspective is that it focuses almost exclusively on the biological basis of depression, effectively dissecting it from other realms of human experience, such as the emotional, community, and environmental realms. Because the brain is considered separately from the rest of the person, it is more likely to be treated without regard to the whole person or to interconnected factors such as one’s environment or quality of life (Leventhal, & Martell, 2006, p. 7; Westgate, 1996, p. 26). In addition, the very use of the DSM, the purpose of which is to facilitate diagnosis, development of treatment plans, and insurance reimbursements, ultimately leads to “the reduction of the whole person to a soul-less, fractionated machine” (Hollis, 2000, p. 101).
A third criticism of the biomedical perspective is simply that it pathologizes depression. While many experts feel comfortable categorizing depression as an illness or disease, in the considered opinions of Read and Stoll (2010) and others, viewing depression solely as a product of disturbed brain operations and deficient neurotransmitters constitutes a grand denial of an individual’s lived experience. It also negates the vital functions that depression may serve, functions that will be explored throughout this paper.

In summary, the biomedical view of depression is problematic because it isolates the biological aspects of depression, at the expense of other important aspects, and primarily targets symptoms with medication, of which the benefits are questionable. This view also predisposes society to label depression as a disease, thus preventing many people from recognizing its transformative potential. This last point will be examined in more detail later. First, though, let us consider a how a holistic perspective can provide a more complete understanding of depression.

**An integral map of a holistic perspective on depression.** Like a biomedical perspective, a holistic perspective on depression can be visualized using an integral map (Figure 3). From this perspective, depression is understood to be a trans-quadrant experience. Because each component of human functioning is inextricably linked to all of the others within a synthesized whole, it is not possible to heal depression by attending to particular phenomena in only one or two quadrants and ignoring the others (Dacher, 2006, p. 133; Westgate, 1996, p. 26). So, for example, in the UR quadrant, rather than only considering the issues of neurotransmitters and behaviors, a holistic perspective might include such factors as nutritional status, co-morbid health conditions, and subtle energy phenomena such as cardiac coherence or the balanced flow of chi energy through the body. In short, a holistic perspective would recognize how phenomena
in all four quadrants give rise to depression as well as how they might be skillfully addressed.

Figure 3. Holistic considerations of depression as viewed in the four quadrants.

Is Depression a Disease?

One of the main differentiating characteristics between a biomedical and a holistic view of depression is whether it is conceptualized as a disease, or as something more. As mentioned earlier, the biomedical perspective tends to categorize depression as a disease. Labeling depression as a disease will almost always lead to treating it with antidepressant drugs, either alone, or in combination with cognitive or interpersonal therapy, which are the only two
psychotherapies currently recommended for treating depression (Granahan, 2005, p. 18; Teodorescu, 2003, p. 100). Electroconvulsive therapy (ECT) is the third modality used to treat MDD (Teodorescu, 2003, p. 100). Unfortunately, while both drugs and ECT have proven to be effective for alleviating symptoms in about half of depression sufferers, rarely do they lead to a complete cure (Ventegodt, Andersen, Neikrug, Kandel, & Merrick, 2005, p. 317).

A somewhat broader view of depression considers the interplay between one’s internal constitution and stress. Research suggests that stress and depression are intrinsically related, with internal or external stressors often serving as the initiators of depressive episodes (Lask, 2011, p. 95). Sapolski (2004), who argued vigorously for a disease model of major depression, proposed that we all have a genetically determined mechanism for self-recovery from stress; however, in depressed people, the mechanism does not work very well (p. 307). While asserting that biological abnormalities predispose people to major depression, however, Sapolski also came to the more holistic conclusion that it is the interaction of biology with psychological, social and environmental stressors that triggers depressive episodes (pp. 300-305).

Still broader views of depression are taken by holistically oriented writers. For example, Moore and McLaughlin (2003) spoke of depression as a “whole body” illness involving all aspects of one’s being (p. 46), while Granahan (2005) described depression as a psychological symptom—not unlike a fever is a physical symptom—that the soul is speaking to us (p. 11). Both Rosen (1993) and Zeuss (1998) contended that depression is a basically natural and healthy response built into the human organism that can enhance one’s ability to overcome difficult challenges. Alternatively, Gordon (2008) considered depression to be a serious wake-up call and a sign that one’s life is out of balance (p. xi).

Perhaps depression is all of these things and more. There is still much to learn about the
etiology and potential purposes of depression for humans in general, not to mention the specific meaning it can have for each individual. The point is, within a holistic paradigm, depression becomes not just a disorder of the brain (UR quadrant), or even the mind (UL quadrant), but a phenomenon involving the whole person (all quadrants). If this is the case, then an individual’s journey to healing will, in one way or another, traverse all of his or her dimensions of being: physical, emotional, cognitive, social, environmental and spiritual.

**The question of quantity versus quality.** Related to the question of whether or not depression is a disease is another question: Are all degrees of depression simply “shades of gray” or points on a single continuum, or is major depression somehow qualitatively different from other, milder forms? Some authors distinguish between healthy depression—the uncomfortable but short-lived episodes of depression that hold the potential for self-healing, personal renewal and an enhanced ability to face life challenges—and unhealthy depression, in which one becomes stuck in repeated and self-perpetuating patterns of chronic negativity and sadness (Rosen, 1993; Zeuss, 1998). Within a holistic paradigm, healthy depression can be thought of as a turning inward toward ourselves, an unpleasant but not unhealthy response to personal losses, either real or perceived. Rosen (1993) described such depression as a “biological conservation-withdrawal mechanism” and a “dark underground, where seeds from dying plants can germinate” (pp. 3-4). If, however, we consider all depression to be abnormal and try to get rid of it, we effectively get rid of its salutary aspects as well. As Granahan (2005) stated: “Life is a series of ups and downs, and . . . it is mostly in the down states that we grow” (p. 5).

At a certain point, however, both holistic and biomedically-oriented authorities seem to agree that healthy or “normal” depression, like an overactive immune system, can pivot from being a source of healing to being a source of illness. For example, claiming a holistic
perspective, Zeuss (1998) also distinguished between normal depression, which he viewed as a natural response that would self-heal once appropriately addressed; and severe depression, which he classified as an illness that arises from unresolved, milder forms of depression (p. 66). Because society views all depression as pathological, though, normal depression is often avoided, ignored, or medicated, which effectively blocks the healing process and leaves people even more prone to severe depression in the future (p. 64). Thus, when prevented from resolving for too long, depression becomes chronic and self-perpetuating, and no longer serves its adaptive purpose.

A few words about terminology. When the word “depression” appears in the following framework, it includes all experiences and degrees of depression (whether officially diagnosed or not) except for bipolar depression and normal periods of grief. A further distinction will be made in the section on energy systems between “normal depression” and “major depression.” “Normal depression” will be used in place of words like “mild” or “moderate” depression to distinguish it from the more confusing DSM terminology, which uses these terms to describe levels of severity in MDD. In the context of this paper, normal depression is used to describe any depression that serves a healthy function, while major depression is used to describe either diagnosed MDD or any depression that has become chronic, stuck, or pulled into a downward spiral. Again, the distinction between normal and major depression will be relevant primarily when it comes to understanding the third perspective in the framework, the energy system perspective. First, however, two other perspectives will be explored.

The Perspectives on Depression Framework

The outset of this paper promised a framework to help make understanding and supporting depression more simple and comprehensible. But simple is not always easy.
Depression is a complex condition, even under the best of circumstances, and because individuals are unique, no two will journey through it in exactly the same way. Read and Stoll (2010) fittingly question: “Which is the right road to true health: pure knowledge from the outside, data gathered from the inside, or a combination of both?” (p. 164). As illustrated in Figure 4, the Perspectives on Depression framework draws upon both of these types of knowledge, on the theory that the more ways we have of perceiving depression, the more we will be able to (1) identify what is needed in a given situation, and (2) connect with people in ways that open them to receiving our support. Three of these ways of seeing—from the outside in, from the inside out, and from an energy system perspective—constitute the proposed holistic framework for understanding depression and supporting individuals on their healing journey.

Figure 4. The three views of the Perspectives on Depression framework.
Outside-In and Inside-Out Perspectives

The first two ways of seeing depression — from the outside in, and from the inside out — are better understood if we picture them on another integral map (Figure 5). According to Wilber (2006), each quadrant can be viewed from both the outside and the inside, such that there are actually eight perspectives that can be taken on any phenomenon in the four quadrants (pp. 33-36). So, for example, we can examine depression in the UL quadrant from an objective, outside view by recognizing that it involves thoughts, emotions, beliefs, and the like, and we can also take an inside view by feeling the interior qualities of the depression. In the LL quadrant, an objective, outside view of depression would include recognizing its attendant social and relational qualities; while an inside view would include the experience of interpersonal relationships and communication that the depressed person co-creates with others. And so on through the quadrants, where the outside view is one of studying and observing while the inside view is one of experiencing.
Looking in from the outside. Already, we have spent much time examining depression from an outside-in perspective. This view of depression was covered in previous sections, wherein the four quadrants of integral theory were briefly described as well as how depression might be viewed from either a biomedical or a holistic perspective. Intake forms and personal interviews are the most common tools utilized by holistic health professionals for assessing clients from an outside-in perspective; if these are used, they should include questions designed to assess possible depressive symptoms in each quadrant.
The outside-in view is a “forest” view in that it allows us to simultaneously see all of the factors that may be influencing a person’s depression, or how depression is manifesting in the four quadrants of the person’s experience. The outside-in view is particularly useful because it enables both the holistic health professional and the depressed person to see the situation from an objective perspective. It is also useful for identifying what types of support will be most appropriate. This support may take many forms, and include anything from listening deeply to the person, to recommending things such as dietary changes, movement therapy or imagery work, to connecting the person with community resources, and more.

**Looking out from the inside.** Although essential, an outside-in view of depression is inadequate and incomplete without its complement, the inside-out view. The inside-out view of depression is the “trees” view. From this perspective, depression is not a static condition, but a journey that “begins with personal awareness of a change in body feeling, and continues as the experience is named, internalized and understood” (Feely et al., 2007, p. 398). Figures 6 and 7 illustrate the inside-out view of depression by pinpointing how a diagnosis of depression might impact a person’s experience both before and after the label “depression” is applied to it. Note that, even with an integral map, it can be difficult to visualize the experience of depression from the inside out, because the very attempt to observe it naturally moves us to an outside-in position. It will be easier if we can continually keep in mind the depressed person’s point of view as we move through the quadrants.

**The pre-diagnosis journey.** Figure 6 illustrates the way someone might experience depression before he has a label to attach to it. For example, in one study, interviewees reported that, long before being diagnosed with depression, so-called “negative impact significant life events” from childhood had greatly influenced their internal self-messages and sense of self-

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worth (UL quadrant) (Feely et al., 2007, pp. 395-396). Believing that their own personal characteristics were to blame for their distressed thoughts and feelings led them to a variety of unhealthy coping behaviors (UR quadrant), such as drinking, people pleasing, self-isolating, staying busy, or applying other avoidance tactics. Finally, triggered by current life challenges, depressive symptoms began to emerge in the psyche (UL quadrant), soma (UR quadrant), interpersonal relationships (LL quadrant), and/or the realm of social and contractual obligations (LR quadrant). As sufferers tried to deal with the depression on their own, not understanding what was wrong with them caused them to worry even more (UL quadrant). Eventually, the increasing isolation and loneliness they felt brought them to the point of asking for help (LL quadrant) (pp. 397-399).
The post-diagnosis journey. At the point of diagnosis, the journey through depression became a qualitatively different experience. This, too, can be visualized from the inside, as an individual struggles to determine what the diagnosis means to him or her (Figure 7). Being labeled as “depressed” is a social phenomenon (LR) that also carries with it cultural (LR) psychological (UL) and physical (UR) implications. The label can serve as a source of psychological legitimization of one’s experience (Feely et al., 2007) (UL), or as a source of increased distress and despair (UL quadrant) and interpersonal isolation and misunderstanding.
(LL quadrant) due to the stigma that society still attaches to mental disorders (Moore & McLaughlin, 2003, p. 47). Finally, the diagnosis will likely limit the knowledge and choices one has with regard to supportive therapies (LR quadrant), as most insurance companies will only cover certain treatments—such as drugs, some forms of psychotherapy, and ECT—should the individual be fortunate enough to have insurance.

Figure 7. An example of one individual’s inside view after being diagnosed with depression.
Why take an inside-out perspective? In a culture that values scientific objectivity and expertise, the inside-out view may be considered superfluous and expendable, if not unprofessional. Why would anyone want to enter the world of someone who is sluggish, morose, and not functioning well at all? Do not such people both need and expect holistic health professionals to be motivators and knowledgeable guides, shining the light on the path forward, and serving as beacons of hope? For educators, healers, and leaders, the urge to help others heal, grow and transform can be powerful. After all, this is where our vision, passion and skills are brought to bear. To advocate for an inside-out view is not to suggest that objectivity and professional expertise are unimportant; indeed they are critical to helping others heal, grow and transform. Nevertheless, taking an outside-in view only will be incomplete and possibly ineffective if we are not able to take the next step. We must also be willing to go further and walk with a person on his or her journey. Theodore Roosevelt is often credited with saying that nobody cares how much you know until they know how much you care. This is the power of being able to imaginatively entering someone else’s world. This is the power of empathy.

Tapping into the inner experience of depression. Although many holistic health professionals have gone through transient periods of depression one or more times in their lives, a much smaller percentage of them have experienced a major depressive episode. One possible way of gaining insight into the latter form of depression would be to read memoirs and autobiographies of people who have experienced it. Another way would be to talk with family members or friends who have gone through it. An even more direct route to understanding the inside view of major depression would be to ask a depressed student, client or patient about her experience, and then to really listen to her without mentally imposing one’s own preconceptions.

In order to enter another’s world, it is vital to create a space where people feel safe
enough to share their true experiences and unedited feelings in a meaningful way. McAdams (1993) said: “If you want to know me, then you must know my story, for my story defines who I am” (as quoted in Moore & McLaughlin, 2003, p. 46). Such authentic personal narratives are important in both education and health care settings precisely because they promote an “inside” understanding and sense of empathy (Moore & McLaughlin, 2003, p. 46). Many professionals, however, even holistic health professionals, are understandably reticent to engage in such conversations. One reason for this is because they believe it will require them to counter negative feelings in an effort to keep things moving in a positive direction. The problem with this approach is that excessive positivity can actually backfire when working with a person who has collapsed beneath the weight of powerlessness and personal failure that depressed people so often feel. Another reason that some professionals hesitate to encourage a depressed person to open up is because of the very practical concern that it will take too long. To counter this concern, Servant-Schreiber (2004) developed a method that can be used to effectively relate to anyone from the heart, often in as little as 10 minutes. Summarized in Figure 8, his five-step “BATHE” technique consists of inquiring about (1) the background of the situation, (2) the individual’s feelings, or affect, (3) what is troubling the individual, and (4) what helps the individual to handle the situation. The technique concludes with step 5, which is expressing empathy to the individual (pp. 193-200).
Used with the intention to enhance direct and authentic connection, and not to control, limit or otherwise expedite an encounter, the BATHE method is valuable for working with depressed individuals because it allows them to feel seen, heard, and cared about, and may also help them to uncover inner resources that they were not even aware that they possess.

**Depression as an Energy System**

Rosen (1993) describes self-healing as a three-fold process that involves (1) understanding—“standing under a difficult situation in order to see it clearly,” (2) transcending—“rising above conflicting forces” in order to get an overview and, (3) transforming—bringing the dark and light sides of depression into balance in order to create life-enhancing change (pp. xxx, 5). So far, we have looked at depression from an outside (transcending) perspective and an inside (understanding) perspective. There is also a third perspective than can help us to grasp the nature and transforming potential of depression, and

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that is the perspective of depression as an energy system. Although not meant to be a foray into advanced scientific theories, the following discussion is included because it dovetails well with both the integral model and with this author’s personal experience of depression.

The energy of depression. According to Dale (2009), the definition of energy in its many forms boils down to three words: “information that vibrates” (p. 4). Dale details important emerging theories and accumulating evidence that humans are more than physical or emotional or even spiritual beings—we are energetic beings. This means that everything, from the thoughts in our minds, to the functioning of our cells, to the connections we form with others is, at the deepest level, made of and influenced by energy. (See Dale, 2009, for a more thorough discussion of the energetic anatomy of humans).

From an energetic perspective, depression may, at first glance, appear to be a problem of too little energy. This is because depressed people often appear from the outside to be vegetating, stuck in the mud, ducking out and giving up. All physical and emotional energy seems to be gone. The energy may not be gone, though; so much as it has gone underground, where it may be used either to guard the gates of the subconscious or to pry them open. Zeuss (1998) maintained that, in depression, at least some aspects of a person’s problems are buried in the subconscious mind (p. 79). On one hand, it takes tremendous energy to hold one’s structures of reality together—even if that reality is not working—and to suppress what needs to be brought into the light. On the other hand, it also takes tremendous energy to bring issues to a place where they may be dealt with and consciously healed. Because the process of dealing and healing requires so much energy, depression can actually be interpreted as a healthy energetic response to difficult challenges. Granahan (2005) indicated as much, asserting that the dampened mood, decreased activity, altered appetite, and increased social isolation that characterize depression all...
can serve to conserve energy for the important inner work of reflection and repair (p. 5).

This model works fairly well when applied to the healing potential of normal depression, but what about major depression? As noted earlier, one of the main characteristics distinguishing major depression from milder forms is that, instead of being able to use depression as grist for healing, the individual spirals down in repeated and self-perpetuating patterns of chronic pain and misery. In this case, it may help to think of a person suffering with depression like a car with its tires stuck in the mud. If not entrenched too deeply, sometimes all it takes is a little forward momentum to free it. However, if the car is not moving, spinning the wheels more forcefully will only make matters worse. Likewise, it is at the point when a person becomes locked into a depressive state, instead of being able to progress beyond it, that depression goes from being a potential aid to healing to being an illness in itself.

One plausible explanation of the role energy plays in major depression comes from Lask (2011), who developed a comprehensive model of depression and recovery based on *nonlinear dynamic systems theory*. Although beyond the scope of this project, elements of this model apply to the current discussion. For example, the model portrays individuals as self-organizing energy systems with a number of self-dimensions—affective, behavioral, relational, somatic, cognitive, and spiritual—that are always exchanging energy with the environment (everything outside the person) (pp. 94-95). Stress, be it internally or externally derived, is believed to be the mechanism of energy transfer that leads to major depression (Lask, 2011, p. 97). In turn, major depression is characterized as “a stable and self-consistent state that spontaneously emerges in order to protect individuals from unbearable circumstances” (p. 1).

This stable state of self-organization could be considered adaptive, in that it minimizes reactivity to the environment and prevents engaging with it in ways that might lead to further
stress (p. 96). However, depression becomes maladaptive if it is prevented from resolving for too long. Figure 9 illustrates two possible paths that the energy of depression can take.

![Diagram of depression process]

**Figure 9.** The depression process can either spiral up to healing or down to despair.

Naturally, this leads to two questions: (1) what can prevent depression from resolving (i.e. perpetuate the “stuck” state), and (2) what can enable depression to resolve? The answers to these questions may be found in the concept of *energy impedances*.

**Energy impedances.** If it is true that everything is made up of and influenced by energy, then energy impedances, as proposed in this paper, can occur anywhere in the four quadrants of human experience where energy is resisted or blocked. Some areas where impedance may originate include the psychological, or “I,” realm (for example, when we suppress things that we are afraid of or do not want to deal with); in the physical, or “IT,” realm (for example, when...
nutrients are unable to enter our cells); or wherever the individual interfaces with the “WE” or “ITS” realms (for example, when relationship conflicts go unresolved, or the conditions we need to thrive go unmet). As with everything else, these energy impedances can be viewed from both outside-in and inside-out perspectives. From the outside, impedances may appear, for example, as internal or external stressors, while, from the inside, the same impedances may be experienced as darkness, heaviness, pain, confusion, conflict, guilt, limitation, isolation or despair. As Zeuss (1998) confirmed, when strong enough, such impedances have the power to interfere with an individual’s innate self-healing abilities (p. 63).

If, as previously proposed, depression is a stable and self-consistent state, then how can it be destabilized without pushing a person deeper into the mire? Or, returning to our earlier car analogy, how can energy be applied to one’s “wheels” in just the right way so that forward movement once again becomes possible? According to Lask (2011), because the human energy system is an open one, it is able to move out of the depressive state under the right energetic conditions (p. 100). Furthermore, the impetus for change need not be huge. Just as a simple mat or a few sticks can be used to provide the traction needed to dislodge a stuck tire, small adjustments to the energy in one dimension of the system can greatly influence the whole. This is where carefully selected holistic modalities are likely to be of the most value.

Implications of the Perspectives on Depression Framework: Using Energy to Restore Balance

Holistic thinkers from many traditions have long held the notion that true health is more than the absence of disease; it is the experience of dynamic balance among and between all areas of life. Like energy impedances, energy balance can be viewed from both outside-in and inside-out perspectives. From an outside-in perspective, for example, balance can be understood in
psychological terms (e.g. balance in the cognitive, emotional, and spiritual realms); in physiological terms (e.g. hormonal balance, homeostasis, or cardiac coherence); in cultural terms (e.g. balance between individual expression and group identification); and in environmental terms (e.g. healthy adaptation within social systems, and harmony with nature). On an even more subtle level, energy balance might be understood as the unrestricted flow of life energy in the form of *chi* throughout the meridian systems of the body (Servan-Schreiber, 2004, p. 121), or of *prana* through the *nadis* of the body (Dale, 2009, p. 242). Likewise, from an inside-out perspective, balance may be experienced variously as qualities such as inner peace, emotional stability, physical wellbeing, spiritual oneness, relational harmony, and social agency.

Whether viewed from the outside in or from the inside out, both impedances and balance can be understood as consisting of energy; in this case, much of the work of holistic health professionals will involve (1) discovering what is out of balance and, (2) supporting the (re)establishment of balance. This same principle applies to depression as much as to any other condition. This is where the skilled and careful use of (outside-in) holistic assessments and application of holistic education, tools and modalities come into play. Of course, certain holistic “prescriptions” may generally be thought to apply to everyone. This is because incorporating things such as good nutrition, movement, relaxation and other self-care practices into one’s life will improve one’s overall balance and function as well as help to provide the energy needed to address more specific issues (Read & Stoll, 2010, pg. 152). The main caveat here is that the holistic health professional should be aware of the urge to apply holistic prescriptions in the same way that a physician would prescribe medication. Treating people with specific protocols according to one’s own area of specialization, if done without regard to the whole person within her or his unique context and circumstances, amounts to holistic reductionism.
Whatever else may be called for, if stress is, indeed, the primary mode of energy transfer that leads to depression, then an equally strong energy is needed to counterbalance it, for example, a heart-based energy. Because the heart has been shown to emit energy in the form of an electromagnetic field that is 5,000 times greater than that of the brain (Dale, 2009, p. 27), this author proposes that heart-based energies such as love and empathy both hold tremendous potential for countering stress and healing depression. Sometimes, such seemingly small things as feeling understood and supported can greatly impact one’s entire energetic system. Combining heart-based energy with the simple acts of creating a safe space and listening deeply to an individual, therefore, may be enough to help him get his “wheels” moving again; that is, to begin moving out of the mire of depression and onto the path of healing.

Application and Future Directions

It is vital for professionals in the field of holistic health to be able to understand and support people who experience depression, for the many reasons detailed in this paper. The Perceptions of Depression framework was designed to illustrate how a truly holistic philosophy—enhanced by principles borrowed from integral theory and theories about energy—may be skillfully applied to depression. While each of the perspectives outlined in the framework is important on its own, combining all three perspectives can create a powerful, synergistic foundation for working more holistically and effectively with depression. This last point is key, given the potential of depression to spiral either up or down, based on the quality of energy that is applied to it.

What distinguishes this framework from much of the advice coming out of the field of personal development? It seems the world has become rife with modern-day gurus promising people that they can eliminate all doubt, pain, negativity, and sense of lack, all while cultivating
abundant health, wealth and happiness. While such proclamations are helpful to many, they are of little use to depressed people, who can end up feeling even worse if they think they should be able to change but feel like they cannot, which only serves to reinforce their sense of “stuckness.” Such teachings are also the antithesis of holistic philosophy that honors the entirety of one’s experience, and considers both good and ill health to be meaningful aspects of the larger whole of life. For those who embrace the latter philosophy, the Perspectives on Depression framework can help them to: (1) acknowledge and accept the full range of one’s inner experience (inside-out perspective), (2) adopt an objective yet compassionate view of the self, understanding the multiple, interconnected ways in which depression may be created and manifested in one’s life (outside-in perspective); and (3) gently shift energy that is stuck into a more healthy and balanced state (energy system perspective).

As for the energy system perspective, we live in an exciting era, when science is beginning to understand how energy is (and always has been) interwoven into the fabric of our existence; it is, in fact, the very stuff of which we are made. Our thoughts, emotions, physiological functioning, relationships and even more can now be thought of in bioenergetic terms (Dale, 2009). No doubt, this growing body of scientific knowledge will continue to merge with philosophical concepts, such as those found in integral theory, to enhance the ability of holistic health professionals to help people “connect the dots” between the mental, physical, emotional, spiritual, relational and environmental realms of their experience.

Until this happens, the Perspectives on Depression framework could be used as a starting point for developing a thorough holistic assessment for depression, and for mapping holistic tools and modalities according to the quadrants in which they are likely to have the most impact. In this way, a holistic health professional could more easily match specific tools to each
individual’s unique situation for maximum effect. In the meantime, holistic health professionals are urged to use the Perspectives on Depression framework to both better understand depression and better assist others and themselves in their journeys of self-discovery and self-healing.
References


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Appendix A

How I Chose This Topic (or How it Chose Me)

Great pain, when it is honored from the heart, opens into great understanding.

~ Jack Kornfield

When people ask me how I came to settle on the topic of depression for my integrative final project, I respond that I did not choose this project; rather it chose me. Over the previous two terms I had wrestled with the decision, and had studied in depth several good options for topics. Unfortunately, at the very same time that I was considering what “contribution” I could make to the field of holistic health education, I was personally experiencing a rather deep and prolonged period of depression. As much as I tried to work around it, focusing on virtually anything else but the problem at hand seemed at best like a huge distraction and at worst futile.

Although I have experienced depression multiple times in my life, I was particularly dismayed that it reappeared at this particular juncture in my educational program. How can this be happening to me now? I wondered. With all of the knowledge and awareness I had amassed about how to live a life that was more healthy, happy, balanced and integrated in mind, body, and spirit, somehow, I believed that I should either no longer be subject to depression, or that I should be able to overcome it on my own by utilizing the tools and techniques I had learned. In short, I felt like a double failure, first, for becoming depressed, and second, for not being able to pull myself out of it, no matter how many tools and methods I tried.

Slowly, however, as I worked with the depression instead of trying to “just snap out of it,” I began to notice that, this time, my experience of depression was qualitatively different. I wasn’t just revisiting the same old territory yet again. Yes, I was still circling the mountain, but at a higher altitude, so that, although many of the landmarks were the same, I could see them
with much more presence and clarity than I had in previous episodes. Among the first things I discovered was that, once I stopped rejecting the depression (and myself for having it), things got perceptibly easier. For the first time, I didn’t just want to escape from depression and never look back; I wanted to learn its meaning and to grow from the experience. However, at the time, I was approaching my depression mainly from an inside-out perspective. I was searching for meaning in the depression, but there was still so much about depression that I didn’t know, and needed to learn.

Finally, just two days before it was time to reveal my topic to my cohort, I heard one yoga instructors make a simple statement that resonated deep in my core. The statement was, *the meaning is in the challenge*. Then it struck me—depression would be the subject of my final project. At first I felt excited, but also scared, for several reasons. First, I am no psychologist, and I knew that much of the literature I would find on depression would be heavily based in psychology. Therefore, I would have to work hard to make sure I didn’t stray too far into the psychological realm; my project must be firmly rooted in holistic theory and principles. Second, as I was still partially submerged in the murky waters of depression, part of me feared becoming overwhelmed by my own inner experience, and thwarted in my efforts to adopt a more objective view. The project was not to be based on my own experience, only informed by it. Third, the topic of depression is *huge*. How to focus in on a slice of it that would be manageable in the time allotted felt daunting. Finally, as a product of discovery and creativity (as well as holistically informed principles), the outcome of the project was anything but certain.

Balancing fear with faith, I chose to accept the challenge and to embark on a journey of learning *about* depression as well as learning *from* it. For this, an integral framework seemed appropriate; first, because it would enable me to focus, not just on the psychological and

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biological aspects of depression, but also on the social and environmental aspects; and second, because it would facilitate taking an outside-in, as well as an inside-out, view. The third view included in my framework, the energy system view, came later as I researched what is known about this aspect of depression and squared it with my own experience.

When I decided to enter the field of holistic health, my primary quest was to expand my knowledge base; somehow I was hoping that accumulating information alone would result in authentic personal transformation. Looking back over my school career at John F. Kennedy University, I can see that, bit-by-bit, I really did stretch, change, and grow tremendously. However, something always seemed to be missing. Then came the depression, knocking on my door once again. This time, would I attempt to hide, deny or repress it, or would I open the door and invite it to come in, sit down, and speak its wisdom to me?

At this point, I need to acknowledge that, while no stranger to the hopeless despair and barrenness of soul that depression brings, I have never experienced what I would call a great depression—not great because it is grand, but because its sheer weight and depth eclipses everything that has gone before it. I do, however, know loved ones and friends who have gone through that particular tsunami of suffering which leaves nothing unturned in its wake. Some have found safety, while others have perished in the storm. This project is a tribute to their beautiful souls as much as it is my own search for understanding.

Plato divided the struggles of the mind into two main categories: disease, and divine gift (Rosen, 1993, p. 4). I personally believe that depression can be both, in that it can diminish our wellbeing and, at the same time, teach us things that we might not learn in any other way. This project is my attempt to make sense of depression within a holistic paradigm, and to share what I have learned with other holistic health professionals. There is much I have learned that is both
personal to me and beyond the scope of this project. Suffice to say, I am in a period of
transformation, not the kind that I originally intended, but the kind that, nonetheless, is bringing
with it a deeper sense of understanding, empathy and connection, to both myself and to others.
Selected Resources for Further Reading

Note: Most of the following books present a combination of holistic and allopathic concepts and approaches to depression, with a few of them being more purely holistic in philosophy than others. Some of the books were chosen because they provide an important inside-out view of depression, and others because they offer a variety of suggestions for understanding and working with depression holistically. While not testifying to their individual levels of accuracy, I believe that all contain valuable information for understanding the multiple, interconnected dimensions of depression.


Servan-Schreiber, D. (2004). *The instinct to heal: Curing stress, anxiety, and depression without drugs and without talk therapy*. Emmaus, PA: Rodale. Written by an M.D., this book includes therapies for depression that are both holistically and scientifically based. Topics covered include heart coherence, EMDR, light therapy, acupuncture, nutrition, love, emotional communication, and more.