Depression, Stigma, and the Soul

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O my Lord, my Beloved, my Desire! Befriend me in my loneliness and accompany me in my exile. Remove my sorrow . . . Verily, Thou art the Gracious, the Generous.

—'Abdu'l-Bahá, *Bahá'í Prayers*

Abstract

Major depression is a global health crisis; it is complex and confusing, and the majority of people who need help do not receive it. The stigma attached to depression and other mental illnesses is one of the greatest barriers to effective treatment. Embedded as it is in history, culture, and even in the medical model, stigma has poisoned the public's perception of those who suffer from mental illness. Public stigma also creates "self-stigma," thereby causing disconnections in relationships and, sometimes, a despair that can lead to self-destructive feelings or suicide. New recovery models including those offered by interpersonal neurobiology are challenging the medical model in the treatment of mental illness. By defining the mind as transcendent and both embodied and relational, new avenues of healing become possible. Health is realized when those with mental health challenges create their own recovery plans and draw on the healing power of the soul within loving and educated communities that support them with friendship, not judgment.

Resumé

La dépression majeure est une crise sanitaire mondiale. Elle est complexe et source de confusion, et la majorité des personnes qui en souffrent ne reçoivent pas l'aide dont elles ont besoin. La stigmatisation liée à la dépression et aux autres maladies mentales constitue le principal frein à une prise en charge efficace. Cette stigmatisation, qui est au cœur de l'histoire, de la culture – voire du modèle médical, empoisonne la perception du public envers les personnes ayant une maladie mentale. Cette stigmatisation publique amène les personnes qui vivent une dépression à se stigmatiser elles mêmes, nuit à leurs rapports avec les autres et entraîne, parfois, un sentiment de désespoir pouvant conduire à des idées autodestructrices ou au suicide. De nouvelles approches en matière de rétablissement, notamment celles offertes en neurobiologie interpersonnelle, remettent en question le modèle médical utilisé pour le traitement de la maladie mentale. En définissant l'esprit comme étant transcendant et à la fois incarné et relationnel, de nouveaux modes de rétablissement deviennent possibles. Les personnes aux prises avec des problèmes de santé mentale parviennent à la santé lorsqu'elles créent leur propre plan de rétablissement et font appel au pouvoir guérisseur de l'âme et qu'elles bénéficient de milieux aimants et éclairés qui les soutiennent en maintenant avec elles des liens d'amitié exempts de jugement.

Resumen

La depresión mayor es una crisis global de salud; es complejo, crea confusión y la mayoría de las personas que necesitan ayuda no la reciben. El estigma atado a la depresión y otras enfermedades mentales es una de las barreras más grandes para

el tratamiento efectivo. Estando arraigado en la historia, la cultura y hasta en el modelo médico, el estigma ha envenenado la percepción del público acerca de aquellos quienes sufren de enfermedad mental. El estigma público también crea "auto-estigma", causando así desconexiones en las relaciones y, a veces, un desespero que puede llevar a sentimientos auto-destructivos y de suicidio. Nuevos modelos de recuperación incluyendo aquellos ofrecidos por la neurobiología interpersonal están desafiando el modelo médico en el tratamiento de la enfermedad mental. Al definir la mente como trascendente y tanto encarnado como relacional, nuevas avenidas de sanación se hacen posibles. La salud es realizada cuando aquellos con desafíos de salud mental crean sus propios planes de recuperación y toman del poder sanador del alma, dentro de comunidades amorosas y educadas que los apoyan con amistad y no juzgándolos.

Introduction

I have been a psychologist for most of my life. A number of years ago, a man I will call George came to see me and told me a story that was shocking but not unusual. George was thirty-two years old and had a good career, a wife, and a one-year-old child. He said that he had been suffering from major depression most of his life, but about a month before our visit he had finally lost hope of ever recovering. Although religious, he believed God would understand that the world would be better off without him. He was in such severe and unbearable emotional pain that he decided to take his own life. To this end, he began to carry through a plan he had been contemplating for many years—since adolescence, in fact. He bought a large supply of over-the-counter painkillers, sleeping pills, and other drugs, and he resolved to take them all at once.

When he got home, he sat down to write a goodbye note to his family, but at that moment, his wife returned early from work and interrupted his plan. She took him to the emergency room. He told the doctor his story, adding that those negative feelings from a few hours earlier had lessened while he had been sitting in the waiting room. He said that he loved his family and wanted to go home. The doctor took blood tests; did a chest X-ray; examined his heart, lungs, eyes, ears, nose, and throat; and pronounced, "OK, you can go home. There is really nothing wrong with you. The problem is all in your head!"

The world is full of people like George—men and women, children and teens, who suffer from major depression. According to the latest information from the World Health Organization, depression is the leading cause of ill health and disability worldwide. According to their estimates, more than 300 million people are now living with depression, an increase of more than 18 percent between 2005 and 2015. Despite the fact that depression is treatable, nearly half of the people who suffer from it do not get the help they need and the figure is much lower in poorer, less developed countries (WHO n.p.).

"Depression: A Global Public Health Concern" reported results of the World Mental Health Survey, which was conducted in seventeen countries and found that on average, about one in twenty people report having had an episode of depression in the previous year (Marcus et al. 6). About one million people take their own lives each year. For every person who commits suicide, twenty more make an attempt (Marcus et al. 6).

The burden of depression is 50 percent higher for females worldwide across all income levels. One or two new mothers out of every ten will suffer from depression after childbirth. Depression limits the mother's ability to care for her child and therefore can seriously impact the child's growth and development (Marcus et al. 6).

According to data compiled by the Centers for Disease Control (CDC), although more women than men are depressed, men are less likely to get help and more likely to commit suicide (1). Suicide was the tenth leading cause of death in the United States for all ages in 2014, and men took their own lives at nearly four times the rate of women, representing almost 78 percent of all suicides (1).

Depression typically starts at a young age, and depressed children and teens often go untreated. Lack of treatment has led to increasing suicide rates among the young. Suicide was the second leading cause of death in the age groups 10–14, 15–24, and 25–35 in 2014 (CDC 2).

Depression and other major mental illnesses affect not only those who suffer from them, but also their families, friends, coworkers, and community members. Often both the sufferers and those who care for them are at a loss about what to do. Even when urged to get help, many with mental health problems seem to resist. Why? And what can be done to remedy this problem?

The goal of this discussion is fourfold: first, to describe major depression; second, to explain the history and dynamics of the stigma attached to major depression and other mental illnesses; third, to show that stigmatizing others or oneself as being "mentally ill" can be a deterrent to treatment and implies (contrary to the Bahá'í teachings) that such illnesses impede the progress of the soul; and fourth, to show how the concept of "accompaniment" can be a major contributing factor to healing when it is informed by a scientifically sound and empathic understanding of the illness.

Confusion about Depression

The word depression itself is very confusing. Webster's Dictionary gives twenty different definitions for the word; only three of them refer to mood issues. Depression, among other things, can be an area of low atmospheric pressure, a downturn in the economy, or low-lying land ("Depression").

Even when referring to an emotional state, in English-speaking countries

the word depression is often used in at least two ways: (1) to describe things, events, or circumstances in the present or in the past that cause a generally negative emotional state, and (2) to denote the presence of a major mental illness—as in clinical depression (also known as major depression) or unipolar mood disorder.[1]

In George's example, the doctor who told him that his problems were "all in his head" was engaging in this confusion. George had a major mental illness (major depression) and needed immediate comprehensive treatment. Because the doctor could not see it with his own eyes or measure it by common medical tests, he decided that the problem was not real. In making this fundamental error, he was blaming George for his illness and putting the onus on him to get over his problems by himself. This error could have cost George his life, but, luckily, George sought treatment elsewhere on his own. The emergency room where he had been seen was also contacted, and this incident was reported. On follow-up, it was found that the erring physician had been reprimanded and sent for further education about mental illness.

If a trained physician can make such a mistake, imagine how much more likely it is that friends, family members, and associates of those who have major depression would do the same. In a sense, it is understandable: the words *depressed* and *depressing* are often used in everyday speech to mean "unhappy" or "disappointing" or to signify other negative emotional states. For instance, a real estate salesman might drive through a "depressing" neighborhood. Teenagers without a date to the prom might say they are "depressed" because they will miss the event. A woman who loses an election to the school board might say she is "depressed" about it. In all these circumstances, a person is experiencing a passing state of negative emotion. Such occasional sadness is a normal aspect of everyday life.

When one is experiencing this kind of everyday sadness or lowered mood, advice to ignore the problem, get busy with other things, or "look on the bright side" may actually be helpful. However, saying the same to a person who is suffering from major depression or other major mental illnesses inflicts a kind of cruelty upon them. It trivializes the seriousness of the illness and adds to it a sense of guilt, shame, isolation, and hopelessness. It is like saying to a person with a broken leg, "You should be more careful" or "It is nothing. Just hop," or saying to a person having a heart attack, "No need to see a doctor. You are probably just out of shape. You need to get more exercise."

Diagnosing Depression

The definitions of mental illnesses are published by the American Psychiatric Association in various editions of

1 Bipolar mood disorder also includes periods of major depression as well as periods of extremely elevated or agitated mood.

the *Diagnostic and Statistical Manual of Mental Disorders*. The latest edition of this volume is DSM-5, published in 2013. The first, DSM-I, was published in 1952. The World Health Organization has its own coding system, published in the *International Statistical Classification of Diseases and Related Health Problems* (ICD). ICD-10 is the current version. This system is used most often for billing purposes.

DSM-5 is a large book that gives detailed explanations of the symptoms of the illnesses and summarizes what is known and not known about their course. Through the various revisions of DSM, different diagnoses have been added or removed. For instance, "neurosis" appears in DSM-I and II but was eliminated from DSM-III and later editions.

Psychiatric diagnosis can be challenging because it relies on self-report and similar symptoms can apply to more than one diagnostic category. Often, more than one diagnosis is appropriate. For instance, substance abuse disorders are often concurrent with depression, anxiety, or other mental illnesses.

While the symptoms of mental illnesses can be grouped together and given labels, their causes are often complicated or unknown. Only the trauma-related disorders like post-traumatic stress disorder have specific and identifiable causes—that is, the trauma itself.

Scientists now use a "biopsychosocial" model to understand mental illness, meaning that complex interactions among biological, psychological, and social factors determine the onset and course of illnesses. Biological factors like genetic predispositions and inherited vulnerabilities are key factors. Psychological contributors include developmental experiences, personality, intelligence, beliefs, attitudes, and other variables. Social factors are, for example, race, ethnicity, socioeconomic status, family relationships, school, work-related variables, community relationships, and religious affiliation.

Despite this complex interplay, biology alone can play a determining role. For instance, in our example, George reported virtually no problems with his childhood, work, relationships, or family life. He had a pleasing personality, low stress, and what appeared to others to be a successful life. Yet he had been chronically depressed all his life. For one whose first-degree relatives have major depressive disorder, the lifetime risk of developing the disorder is two to four times greater than for those without this risk factor. In his "Overview of the Genetics of Major Depressive Disorder," Falk W. Lohoff reports a recent review of twin studies that estimates heritability at 37 percent, "with a substantial component of unique individual environmental risk but little shared environmental risk" (540).

How Experiences of Depression Differ

Given that the word *depression* can indicate "just a bad day" or a major mental illness, how can an observer tell the difference? The answer is, you cannot.

There are many reasons for this. Depression symptoms differ from person to person and may vary from day to day. Those who suffer from it often hide or minimize their symptoms, or they may not even know they are depressed.

Depression is almost impossible to describe and even harder to comprehend unless it has been experienced first-hand. Nevertheless, I asked friends, family members, and former clients to help me try to describe what it is like to be depressed (names have been changed and descriptions edited for confidentiality).

A middle-aged man named Ken described it this way: "When you are depressed, life is a struggle, a burden, like carrying a one hundred-pound weight on your back all day every day. It is hard to get out of bed in the morning. Sometimes, I eat and eat and eat just to try to get some energy, but then, sometimes, I have no appetite at all. Over the years, I have gained and lost weight like crazy. The same with sleep. Sometimes I want to sleep for days and can hardly move, then other days I'm so agitated, I toss and turn all night. I can't say I am sad. It feels more like a numb nothingness that makes me feel profoundly ashamed and guilty. I know I have no reason to feel this way, but knowing it doesn't change anything. My thoughts seem to have no power over my emotions."

A teenager named Josiah said it is "like trying to drive your car when the engine is dead. I tell someone, 'I am not going anywhere; I can hardly move,' and they say, 'Did you put the key in the ignition? Did you check the gas? How old is the battery?' And it makes me mad because the problem is none of the normal things you think about. There isn't a cause that makes any sense. There isn't a solution either because nothing in your life explains how unbearable you feel."

Cyrus, a young African-American man, described depression as a "fundamental confusion between pleasure and pain." He said that when he is depressed, nothing that used to bring pleasure is even remotely of interest. In addition, he explained, "The feeling of not being like anyone else is huge. You feel like you don't deserve anything either. You feel so different, so apart from everyone, and so unable to begin to explain it even to yourself. There is no choice except to be alone and hide."

Li, an elderly Asian woman who has had recurring bouts of depression all her life, explained that when she feels "normal," she can't even remember what it felt like to be depressed: "It feels like that depressed person was someone else." But when the cloud of depression begins to rise, it beckons to her, calls her, as if to home. Although vaguely recognizable as a state of pain and despair, it also feels familiar and therefore strangely attractive. As the condition gets worse, she sinks into it and away from her previously healthy life. She becomes lost in the darkness of her low mood and increasingly unable to function. At her lowest point, she may have only a vague, faint

remembrance of her formerly healthy self.

Doris described depression as "a black cloud invading your mind, overwhelming your thoughts and senses, the mental equivalent of being naked in the cold—no blanket, no warm fire. And at the same time there is a knife stuck in you and you can't escape it because it feels like it is you, and the only escape is to destroy yourself. Your survival instinct is overridden by the enormity of the pain and the inescapable nature of it. It feels like oppression coming from an unknown place." She added poignantly, "The worst form of oppression is when your own mind turns against you."

The Many Masks of Depression

A recent Twitter conversation (#mydepressionlookslike) gives a glimpse into the many faces of depression.[2] Many tweets express the painful loneliness and isolation of depression, the need to hide the illness, and the feeling that no one really understands. Examples include, "I'm absolutely fine, literally, you wouldn't know anything was wrong by looking at me & that's the dangerous part"; "smiles, cookies, tears in the bathroom, running, laughter, screaming into a pillow"; "kindness to others but not myself"; "being told 'I'm too bubbly and happy to be depressed' which only reminds me of the facade I portray every day"; "being always asked 'what's wrong' but not knowing how to even answer that question"; "just trying to survive, and make it through another day"; "weakness, black men can't be depressed"; "wishing that more people would understand that you're not choosing to be like this, you're not just lazy." The tweets go on and on, reflecting the fact that depression is a complex, highly individualized experience. Between persons, symptoms can look quite different, and within any individual person who is depressed, symptoms can fluctuate greatly from day to day or week to week.

Depression can wear the mask of other problems. It can seem like laziness, lack of motivation, or procrastination. It can feel like being "burn out" or having a "mid-life crisis." Because depression can cause fatigue, aches, pains, and a feeling of being slow, heavy, and ready to give up on life, it can be misinterpreted as a sign of aging. Problems with concentration or memory may suggest early dementia. Common physical symptoms like low energy and problems with sleep and appetite could suggest a medical problem, while less common symptoms like cardiac arrhythmias, loss of libido, loss of hearing, decrease in body temperature, sweating, nausea, vomiting, dizziness, sensations of cold, etc., are frequently misdiagnosed as medical, rather than psychiatric, problems.

Depression can masquerade as anxiety, and because these conditions often occur together, many people think that their depression is "just stress." Anxiety can express itself as nervousness,

2 See http://twitter.com/hashtag/mydepressionlookslike/.

restlessness, tension, feelings of impending danger, panic, doom, and worry. It can include physical symptoms like heart palpitations, sweating, and rapid breathing. Anxiety attacks, also known as panic attacks, can mimic the feelings of a heart attack.

Chronic feelings of depression and anxiety sometimes lead to addictive behaviors meant to mask or reduce internal distress. Over time, addictive behaviors become problems in and of themselves. Addictions include not only drug and alcohol abuse, but also things like obsessive over-work, eating disorders, excessive exercise, Internet addiction, sex addiction, gambling, and other obsessive behaviors.

Despite the complexity and overwhelming difficulty of living with major depression and other mental illnesses, people manage to do it. In fact, many famous and successful people have suffered from major depression including Abraham Lincoln and Winston Churchill (Solomon, 367). Writers Ernest Hemmingway, Walt Whitman, Mark Twain, Stephen King, and J.K. Rowling have openly admitted to battling low moods, while entertainers like Billy Joel and Ray Charles expressed their inner struggles through music. Prince Harry of Great Britain has recently opened up about his chronic depression caused by unresolved grief over the death of his mother, Princess Diana, when he was only twelve years old. He now speaks candidly about his difficulties, including delaying treatment because of the stigma of mental illness, and is urging open conversations about these topics.

He is not alone. Stigma has been identified by experts as the single leading cause of treatment avoidance. The following story will illustrate how prejudices and false ideas work to needlessly prolong the suffering of those who need professional help.

How Stigma Prevents Treatment

Juanita came for counseling at the insistence of her parents. She had recently become engaged and had asked her parents for permission to marry as Bahá'í law enjoins. They had refused, insisting that she see a counselor before they would agree to discuss it again.

Juanita, by now in her mid-thirties, had experienced a lifetime of struggle with depressive symptoms including low mood, crying spells, problems with decision-making, procrastination, and feelings of insecurity. However, she did not believe that she was depressed. She was fine—after all, she was getting married!

After doing some work with me, Juanita began to realize that she was using her relationship with her prospective husband as an "anti-depressant." When she was around him, she felt less sad and more like herself. In her mind, the relationship "proved she was normal" and not "a crazy woman." Admitting the need for treatment, she explained, would lead to a downward spiral that would cause her to "end up in the loony bin." She believed that "fighting" her illness meant avoiding treatment, while admitting her need

for help was tantamount to "giving in." She also believed that if she took anti-depressant medication she would get "hooked on drugs" and would have to take them for the rest of her life. She said she did "not want to get her happiness from a pill." These are common fears and misconceptions that are erroneous.

Getting help decreases the severity of the illness and increases the likelihood that when it passes, it will not recur. Often it is not necessary to take anti-depressant medications on a continuous basis. Anti-depressant medications are not addictive, and taking them allows the body's normal mood to return. Using medication to fight depression is only one choice among many within a person's individualized wellness plan. The "loony bin" is a pejorative term for a mental hospital. Most people who need treatment for depression do not need to be hospitalized as part of their treatment. Only if depression goes untreated and gets so severe that the person becomes a danger to himself or herself or others (like George in the above example) might it be necessary to go to a hospital for a short time.

Juanita's barriers to treatment included not only misinformation about her illness, but also all the prejudices and false beliefs she had internalized from her family and culture. She explained that according to her family, people are supposed to "pull themselves up by their own bootstraps" and "quit whining and complaining and feeling sorry for themselves," and that they believed seeking help for depression was a sign of a poor character, weakness, and not relying enough on God. Juanita thought that if she prayed properly, God would take away her depression. It followed that if He didn't, it meant that she wasn't praying right or hard enough.

Juanita not only believed her own prejudices about getting help; she thought that others did as well: she felt that if she told her fiancé about her depression, he would not want her because she would be "defective merchandise." And being labeled "a nut case" would ruin her chances of marriage. "No one would ever want me," she said.

As Juanita and I talked more, she began to realize that she was not being honest with herself or with her fiancé. She was racing toward marriage, trying to outrun her depression before, in her words, "it took over and ruined my chances of living a good and normal life forever."

Juanita's statement is the essence of stigma—the prejudiced idea that there are two groups of people in the world, the "normal" and the "not normal," those who have mental illnesses and those who don't. It is an "us vs. them" way of thinking in which admitting mental health problems creates an inescapable mark of inferiority that separates one from mainstream society.

At the beginning of our work together, Juanita could not associate the idea of "a good, normal life" with "a mental illness like depression." It was either one or the other. This is not

true, but such beliefs have a long history and are deeply rooted in many cultures around the world.

The Historical Roots of Stigma

Early Egyptian, Indian, Greek, and Roman writings attribute mental illness to the displeasure of the gods or possession by evil spirits. The sufferer was blamed for the illness and treated as a pariah, an outcast deserving exorcism, torture, or even death. This view prevailed despite efforts by Hippocrates around 400 BC to attribute mental illness to brain pathology.

Throughout the 1800s and early 1900s, the notion that humane treatment for those with mental health problems would be curative began to take hold, but fears and misinformation from earlier times remained. Effective treatments were lacking, and those with mental health problems continued to be institutionalized with criminals, the poor, and those with other chronic illnesses.

From the mid-1900s to the present time, medical experts developed more and better treatments for major depression—most notably, a whole range of psychotropic medications and evidence-based psychotherapies. In the United States, some efforts were made to address mental illness through government measures. However, such initiatives suffered from poor funding and lack of follow-through.

Meanwhile, the American medical insurance industry has been allowed to capitalize on the stigma surrounding mental health by creating two separate insurance systems, one for "medical" problems and one for "mental" problems. The separation permits the allocation of inferior coverage for mental health treatment and leaves many who need help unable to obtain it.

Stigma—Prevalent, Potent, Pernicious

Sociologist Erving Goffman is usually credited with the first systematic exploration of stigma. In his book *Stigma: Notes on the Management of Spoiled Identity*, he describes it as the social phenomenon of being rejected by a peer group on the basis of an attribute the group finds unacceptable (6–7). Goffman lists three categories of stigmatized people: (1) those with "abominations of the body"—now known as physical disabilities; (2) those with "blemishes of individual character perceived as weak will," among which he included mental disorders, addiction, alcoholism, suicide attempts, imprisonment, homosexuality, unemployment, and radical political behavior; and (3) those with the "tribal stigma" of race, nationality, and religion (6–7). The follow-up to Goffman's work over succeeding decades became bogged down with controversies about the labeling process itself and whether or not it caused stigma. That issue was never resolved, and as interest in the topic waned, the notion that stigma was declining took hold. Meanwhile, mental health became a human rights issue.

From the 1970s onward, battles within the legal system focused on fair housing, equal employment opportunities, and adequate medical and psychiatric care for those who need it. The Bazelon Center for Mental Health Law[3] has been working in this area for many years. An exhaustive treatment of this topic is outside the scope of this paper, but a few landmark cases from its website are noteworthy. For instance, in the 1970s, *Wyatt v. Stickney* established the constitutional right to treatment for people with mental disabilities committed to state institutions, and *O'Connor v. Donaldson* established the right to freedom from custodial confinement for non-dangerous persons. The Fair Housing Amendments Act of 1988 made it illegal to deny access to housing based on physical or mental disability. In 1990, the far-reaching Americans with Disabilities Act rendered discrimination based on mental or physical disability illegal, just as the Civil Rights Act of 1964 had outlawed discrimination based on race, color, religion, sex, or national origin ("Our History").

At the turn of the millennium, when serious attention from the social sciences returned to the issue, the stigma associated with mental illness was found to be prevalent, potent, and pernicious. In 1999, the first ever Surgeon General's Report on Mental Health reviewed the literature on mental health treatment and found that stigma was "the primary barrier to treatment and recovery" (Office of the Surgeon General et al. viii). The report notes that the general public still believed Goffman's premise that mental disorders are the result of "moral failings or limited will power" (viii) It also over-optimistically predicts that "[w]hen people understand that mental disorders . . are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate" (viii). It thus calls for mental illness to be defined as a physical dysfunction, a "disease like any other" (viii).

Following the Surgeon General's report, what were supposed to be "anti-stigma" campaigns were launched to convince people that mental illness was a brain dysfunction. For instance, in the United States, the National Alliance on Mental Illness launched the "Campaign to End Discrimination," which emphasized the neurobiological bases of mental illness and the need for pharmaceutical treatments. Within the following decade, in countries in North America and around the world, similar widespread and expensive campaigns emphasized the brain disease model.

Research indicates that in many ways, rather than reducing stigma, these campaigns made it worse. A study compared data from the 2006 National Stigma Study-Replication to the 1996 MacArthur Mental Health Study. In both studies, the same vignettes were

3 Based in Washington, DC, the Bazelon Center for Mental Health Law is an organization that provides legal advocacy for people with mental disabilities.

presented to respondents, who were asked to imagine themselves interacting with a person with a mental health diagnosis. The report concluded, "No significant decrease was reported in any indicator of stigma, and levels remained high" (Pescosolido et al. 1324). A majority of the public continued to express an unwillingness to work closely or socialize with persons diagnosed with mental illness or have them marry into their family. And while believing mental illness to be a neurological problem was correlated with believing treatment is necessary, it was also correlated with believing the problem to be irremediable. More alarmingly, many people in the 2006 survey spontaneously volunteered the information that they associated mental illness with an increased risk of violence.

The Perception of Violence Risk

Research has shown that the vast majority of those with mental illness are not dangerous. Having a mental illness is not a predictor of violence within the general population. In fact, mentally ill people are more often the victims of crime than its perpetrators (Torrey 1–5).

"But," you might ask, "what about all the media reports on mass shootings? Aren't all these committed by mentally ill people?" The answer is complicated.

For many years, the Carter Center in Atlanta, Georgia, has worked to increase mental health treatment and decrease stigma around the world. Its efforts have been focused on the importance of the media in the fight against stigma. Research has shown that the public perception that people with mental illnesses are dangerous has been fueled by media reports of hugely dramatic and destructive acts of violence committed by a very small number of people who are not getting adequate treatment. While such acts are statistically rare, they powerfully create and sustain negative public attitudes. The Carter Center has been working to educate the media about their responsibility to provide balanced coverage of the issue of mental health challenges. It provides scholarships to journalists who work on projects that emphasize the success of people with these illnesses: the resilience, the significant achievements, and the everyday happy lives of people in mental health treatment.

In terms of violence risk in the general population, having a mental illness can raise the risk of committing a violent act if the illness is very severe, causing a break with reality, and if the illness is not being properly treated. Even then, the increased risk of someone committing a violent act like homicide compared to someone in the general population is believed to be "about 2% or less" (Torrey 1). However, the criminal justice system has amassed a large number of cases involving these severely ill individuals because the lack of available psychiatric hospitals has left many homeless and without treatment or sufficient resources to survive.

The Development of Self-Stigma

Social psychologist Patrick Corrigan is one of the most well-known experts in the field of mental health stigma.[4] He explains that it is important to acknowledge that stigma is not a figment of the imagination of those who suffer from these illnesses. "The problem of stigma," he and mental health services researcher Nev Jones write, "does not lie within the individual with the mark, but rather in the stigmatizing communities in which the individuals find themselves" (Jones and Corrigan 9). Corrigan's work shows that negative community attitudes (public stigma) can be internalized by the sufferer and become "self-stigma." The story of Juanita is a good example; her story shows how internalized prejudicial beliefs distorted her thinking and presented a major barrier to her seeking treatment.

Corrigan, Benjamin G. Druss, and Deborah A. Perlick distinguish between three main types of stigma: public, structural, and self-stigma. Public stigma refers to the attitudes of the general public that are outlined above. Structural stigma occurs when the prejudices against those with mental health problems become reflected in the government and community infrastructures. The ongoing legal battles and biases in the healthcare delivery system discussed above are examples of structural stigma. Self-stigma occurs when the prejudicial attitudes of the public sector are co-opted by individuals with mental health challenges like depression.

As Corrigan, Jonathan E. Larson, and Nicolas Rüsch explain, self-stigma develops through three separate but related processes: stereotyping, prejudice, and discrimination (75). The first component, stereotyping, can be relatively benign. *Webster's Dictionary* defines stereotyping as a process of unfairly believing "that all people or things with a particular characteristic are the same" ("Stereotype"). Social groups share stereotypes as part of their common culture, and these assumptions are often reinforced in the arts and media. It is easy to think of some of them: "the suit," a conservative banker who dresses impeccably; "the class clown," a middle-school boy who is disruptive but funny; "the soccer mom" with her minivan and workout gear.

Corrigan, Larson, and Rüsch contend that while stereotyping itself is somewhat inevitable and not necessarily damaging, it can be dangerous when it opens the door to the second and third aspects of the stigmatization process, prejudice and discrimination. When stereotypes become fixed negative beliefs about a group, they are

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4 Corrigan identifies himself as a survivor, researcher, and advocate. His website (http://www.stigmaandempowerment.org/) provides tools and resources to empower those with mental health challenges. Recently, he was appointed editor in chief of *Stigma and Health*, a newly created journal of the American Psychological Association.

called "prejudices." When large segments of society begin to share those prejudices and act upon them, discrimination is the result (81).

It is important to understand how this counterintuitive and often unconscious process of self-stigmatization works because self-stigma can combine with the symptoms of depression to create a sense of hopelessness and treatment avoidance that can lead to suicide. Corrigan, Larson, and Rüsch call this the "why try" effect (75).

In the following hypothetical example, Carl will self-stereotype himself as a "geek" and stereotype his coworkers as "artsy types." Then, based on these prejudices, he will imagine a sequence of events that will lead him to discriminate against himself.

Carl, is a gifted programmer who moved from a San Francisco technical firm to a New York City advertising and media firm. Six months into his new job, the creative arts department staff invited him to a party. He wanted to go because he felt lonely. He had been having difficulty making friends in New York. In California, he and his friends had hiked together on weekends and played video games at lunch. These New York "urban artsy types," as he called his coworkers, didn't share his interests in computers and the outdoors. He began to notice that they often referred to him as "our new geek" or, sometimes, "the nerd." He had never been called that before and wasn't sure how to react.

At first Carl tried to convince himself it was a just a joke. But the label stuck, and as time went on, he began to adopt it, even introducing himself to other people as "the new geek in tech support."

The day before the party, Carl began to imagine himself being there. He thought, "I am a bit shy and serious. I wear T-shirts and a hoodie all the time. Sometimes when people tell a joke, I don't get it." In his mind's eye, he imagined himself as "the geek" sitting alone at the party, feeling sad and ashamed because he doesn't fit in, so he eventually decided not to go. On Monday morning, a coworker said to him, "Hey Carl, we missed you last Saturday night! What were you doing?" Carl looked down at the floor and mumbled, "I played video games" as he walked away. The coworker, feeling snubbed, thought, "I guess you really are a nerd."

Carl's self-stigma blocked his view of reality. He didn't know that when his coworkers met him, they immediately liked him. They were fans of the television show The Big Bang Theory, in which a "nerd" hero creates comedy out of his extreme intelligence and lack of social skills. Carl's coworkers were comparing him to their hero when they used that label. For them it was a benign stereotype. But Carl didn't know that. Instead of going to the party and testing his theory of being an outcast, he stigmatized himself and stayed home, thereby effectively creating the reality of being an outcast through his own actions.

Label Avoidance and the "Why Try" Effect

The self-stigma that kept Juanita from getting mental health treatment is in some ways similar to Carl's self-stigma. Juanita labeled a depressed person like herself "a nut case" and saw herself as "less than" someone who does not need mental health treatment (prejudice). She then acted on her beliefs when she avoided treatment (discrimination). Juanita was engaging in what Jones and Corrigan call "label avoidance," which he defines as "refusing to get help for mental illness in order to avoid the label of being mentally ill" (19).

However, Juanita's self-stigmatization is different from Carl's in two important ways: first, Carl was simply feeling a bit sad about missing his friends, but Juanita was suffering from a serious mental illness, major depression; second, while Carl's coworkers actually liked him, a large portion of the general public holds negative views about people with mental health issues.

Juanita had to choose between getting treatment and potentially losing the supportive network of her fiancé, friends, and family, and refusing treatment to keep her social network. Can she be blamed for choosing to maintain her relationships? Is it fair to ask a person suffering from feelings of hopelessness and self-loathing to fight public opinion that decades of social science research, public relations, and government programs have failed to impact?

This is the reality for people with major depression. They are squeezed between the pain of their own illness and the scourge of public opinion, forced to choose between the rages of their own internal suffering and the loss of their sustaining ties. And as a society, we are asking them to face this unsolvable dilemma at the very time they feel most vulnerable and least able to cope, at a time when all the symptoms described at the beginning of this article are in full force. Is it any wonder that many find themselves boxed into a no-win, no-way-out conundrum that leads many to feel death is the only solution?

Mind, Soul, and Relationships

The above discussion reflects the complexity of depression and stigma. Depression and other mental illnesses are private, and they are public. They are widespread throughout the world yet uniquely expressed within each individual. They are embedded in relationships yet deeply personal and intrapsychic. Genetics play a roll, but they only partially explain the complex, life-threatening challenges of depression and other major mental illnesses. Decades of research and public campaigns have failed to eradicate stigma, and the widespread phenomenon of untreated mental illness goes on. In fact, the problem seems to be getting worse. What can be done?

The soul is a timeless concept. Bahá'ís believe in the soul, as do the followers of most of the world's

major religions dating back to ancient times. Aristotle, Socrates, and many other ancient philosophers spoke of the soul. Indigenous and Native peoples also affirm the existence of our link to the Great Spirit that provides guidance during this lifetime and the next.

However, introducing the concept of a "soul" into a discussion of problems that have variously been defined as the province of medicine, psychiatry, sociology, law, and public health may seem incongruous, even contrived. But consider for a moment: perhaps the intractability of stigma is related to the framework within which it has been addressed. Perhaps the approaches reviewed above contributed to stigma by labeling and categorizing human beings rather than seeing them as unique, complex, multifaceted, and transcendent. Perhaps when dimensions like wholeness, interconnection, soul, and spirit are eliminated and replaced with static categories and negative labels, stigma is the result.

Starting with the Enlightenment, Western research and practice in most fields of science removed any considerations of the spiritual nature of mankind. As technology and science rapidly advanced, the dominant paradigm became materialistic and mechanistic. From this perspective, the only things that exist are those that can be observed and measured. That is why the doctor in the emergency room told George his problems were not real after his lab tests proved to be negative.

Mechanistic ideologies see humans as machines whose separate parts add up to the whole. The example of a broken clock is often used as an example. If the clock isn't working, take apart the pieces one by one, find the broken piece, fix it, then put the clock back together. According to this logic, if the problem is depression, label the depressed group "not normal," separate it from the "normal" group, analyze the parts that appear to be "broken"—concrete, physical, measurable things, such as chemical imbalances—then fix those with equally concrete, physical, measurable things like medications.

Notice the actions involved in this approach that contribute to stigma: labeling, separating, defining as broken, assuming an outside expert is needed to fix the brokenness, and ignoring all the unquantifiable aspects such as social relationships, inner psychic thought processes, spirit, and soul. Although slightly exaggerated for the sake of making the point, this is essentially the biomedical model of health. It prides itself on being hard science because it shows cause and effect as linear, fixed, and measurable. Within this model, there is no room for the least measurable, least quantifiable, most ineffable aspect of a human being, the soul. Could it be that without a framework that includes the transcendent, the problem of stigma and the puzzle of recovery from mental health issues cannot be solved?

Daniel Siegel is a clinical professor of psychiatry at the UCLA School of Medicine and the founding co-director of the Mindful Awareness Research

Center at UCLA. In his popular work *Mindsight*, he tells the story of his own struggle with trying to help people within the boundaries imposed by the medical model. It nearly drove him out of the field. He took time off from his training, and when he returned, he was determined to take a different stance. The result is his lifework, called "interpersonal neurobiology," which is taught through his books, lectures, and the Mind Sight Institute (www.mindsightinstitute.com).

Mindsight begins with the question, "What is the mind?" A basic question, it would seem, in a field named "mental health." But, he says, no one really knows. He polled over eighty thousand experts about whether or not they had ever attended a course or lecture defining the mind or mental health: "The responses were easy to count. In numerous countries on four different continents, in lecture halls around our globe, the same statistic has emerged again and again: Only *2 to 5 percent* of people in this field had ever been given even a single lecture that defined the very foundation of their specialty—the mind" (51). Siegel set out to do just that, and his work is noteworthy in many ways.

In Siegel's model, the mind is not a material thing but rather an integral part of the interplay among three aspects within what he calls the "triangle of well-being"—mind, brain, and relationships. "The mind," he says, "is a relational and embodied process that regulates the flow of energy and information" (11). His model emphasizes the relational aspect of individuals and the theory, skills, and benefits of personal growth and changes in states of mind. He suggests that through self-awareness we can become mindful of our own internal subjective states and how these directly shape our physiological and psychological health. He explains that through this awareness, we can change the organization and structure of our own brains. He calls this awareness "mindsight" and describes it as a process that "enable[s] us to sense and shape energy and information flow" (55). Higher states of consciousness lead to transcendence, in which people simultaneously see themselves as unique individuals and part of the entirety of humanity, the whole of creation (52). "Mindsight," Siegel explains, "takes away the superficial boundaries that separate us and enables us to see that we are each part of an interconnected flow, a wider whole. By viewing mind, brain, and relationships as fundamentally three dimensions of one reality—of aspects of energy and information flow—we see our human experience with truly new eyes" (58).

He emphasizes that self-reflection is at the heart of mindsight. He reports that when people become more internally integrated and insightful about themselves, "[t]heir identity expands; they become aware that they are part of a much larger whole. In various research explorations of happiness and wisdom, this sense of interconnection seems to be at the heart of living a life of meaning and purpose" (76).

Siegel's definition of mental health is "integration." He says, "With integration, we see ourselves with an expanded identity. When we embrace the reality of this interconnection, being considerate and concerned with the larger world becomes a fundamental shift in our way of living" (260). Siegel uses brain science to argue that the "mind" can change the brain and therefore behavior. "The mind uses the brain to create itself," he says (261).

Compare this description of the integrated mind with 'Abdu'l-Bahá's description of the rational soul in *Some Answered Questions*:

> The human spirit which distinguishes man from the animal is the rational soul, and these two names—the human spirit and the rational soul—designate one thing. This spirit, which in the terminology of the philosophers is the rational soul, embraces all beings, and as far as human ability permits discovers the realities of things and becomes cognizant of their peculiarities and effects, and of the qualities and properties of beings. (55:5)

While Siegel's definition of the mind and 'Abdu'l-Bahá's definition of the soul are not completely identical, they are compatible. The soul as described here is dynamic, a process and not a static or material "thing." It "discovers the realities of things" (55:5). The soul includes understanding and gaining insight about "peculiarities and effects" (55:5), just as Siegel asserts that "mindsight" allows one to monitor and modify the flow of information internally. Siegel says that the mind cannot be separated from relationships with others. The process of the soul is concerned with relationships too, with "the qualities and properties of beings" (55:5). Both definitions emphasize growth, discovery, and the acquisition of knowledge. Both affirm a human spirit that connects us all together in an integrative whole. Both allow for complexity and connections among seemingly disparate parts. 'Abdu'l-Bahá states, "Reflect upon the inner realities of the universe, the secret wisdoms involved, the enigmas, the inter-relationships, the rules that govern all. For every part of the universe is connected with every other part by ties that are very powerful and admit of no imbalance, nor any slackening whatever" (*Selections* 137). Furthermore, in *The Promulgation of Universal Peace*, 'Abdu'l-Bahá declares, "Religion must conform to science and reason; otherwise, it is superstition. God has created man in order that he may perceive the verity of existence and endowed him with mind or reason to discover truth. Therefore, scientific knowledge and religious belief must be conformable to the analysis of this divine faculty in man" (96).

The preceding discussion shows that love is good science and that the powerful reality of the human soul and spirit defines human beings regardless of the barriers that may at times dim their lights.

"Consider the Light of the Lamp"

That movement toward the spiritual and transcendent is necessary to address mental health was also affirmed by Shoghi Effendi in a letter to an individual believer dated 12 April 1948. He reflects:

> It is very hard to be subject to any illness, particularly a mental one. However, we must always remember these illnesses have nothing to do with our spirit or our inner relation to God. It is a great pity that as yet so little is really known of the mind, its workings and the illnesses that afflict it; no doubt, as the world becomes more spiritually minded and scientists understand the true nature of man, more humane and permanent cures for mental diseases will be found. The Guardian, much as his heart goes out to you in your fear and suffering, cannot tell you whether electric shock treatments should or should not be used, as this is a purely medical question, and there is no reference to such details in our Scriptures. The best scientists must pass upon such methods, not laymen. You must always remember, no matter how much you or your others may be afflicted with mental troubles and the crushing environment of these state institutions, that your spirit is healthy, near to our Beloved, and will in the next world enjoy a happy and normal state of soul. Let us hope in the meantime scientists will find better and permanent cures for the mentally afflicted. But in this world such illness is truly a heavy burden to bear! (qtd. in *Selections from Bahá'í Writings* 948)

In this letter, Shoghi Effendi celebrates the power of the soul, emphasizes its inherent health, and describes illness as a "hindrance" between the soul and the body, a point also underscored by Bahá'u'lláh:

> Know thou that the soul of man is exalted above, and is independent of all infirmities of body or mind. That a sick person showeth signs of weakness is due to the hindrances that interpose themselves between his soul and his body, for the soul itself remaineth unaffected by any bodily ailments. Consider the light of the lamp. Though an external object may interfere with its radiance, the light itself continueth to shine with undiminished power. In like manner, every malady afflicting the body of man is an impediment that preventeth the soul from manifesting its inherent might and power. (*Gleanings* 153)

Siegel's work suggests that when a person is experiencing maladies that affect the mind, relationships, or "soul to soul" connections, can wield a powerful force. Within loving relationships, the positive energy flow helps

buttress those who are experiencing mental health challenges. Conversely, stigma and related negativity like judgment, criticism, or relationship "cut-off" can cause irreparable damage. The Bahá'í community, with its emphasis on love, community building, and reliance on the spirit, is uniquely suited to respond to the needs of those who suffer from mental illness.

Accompaniment and Recovery

Accompaniment is a concept that has recently become a lodestone of community building efforts within the Bahá'í Faith. To accompany someone is to stand next to that person and "be there," supporting him or her with understanding and empathy. Accompaniment is neither giving advice nor abandonment. It is non-judgmental supportive friendship, a soul-to-soul relationship in which each learns from the other.

> O children of men! Know ye not why We created you all from the same dust? That no one should exalt himself over the other. Ponder at all times in your hearts how ye were created. Since We have created you all from one same substance it is incumbent on you to be even as one soul, to walk with the same feet, eat with the same mouth and dwell in the same land, that from your inmost being, by your deeds and actions, the signs of oneness and the essence of detachment may be made manifest. Such is My counsel to you, O concourse of light! Heed ye this counsel that ye may obtain the fruit of holiness from the tree of wondrous glory. (Bahá'u'lláh, Hidden Words, Persian no. 69)

The Bahá'í Writings are very explicit in regard to what a relationship would look like when walking "even as one soul." This beautiful and moving passage sets a new standard of friendship for all of us. 'Abdu'l-Bahá says that

> the Cause of the Ancient Beauty is the very essence of love, the very channel of oneness, existing only that all may become the waves of one sea, and bright stars of the same endless sky, and pearls within the shell of singleness, and gleaming jewels quarried from the mines of unity; that they may become servants one to another, adore one another, bless one another, praise one another; that each one may loose his tongue and extol the rest without exception, each one voice his gratitude to all the rest; that all should lift up their eyes to the horizon of glory, and remember that they are linked to the Holy Threshold; that they should see nothing but good in one another, hear nothing but praise of one another, and speak no word of one another save only to praise. (*Selections* 193)

'Abdu'l-Bahá has given a clear answer to the question, "How do you accompany a person with mental health challenges?" Extol without exception. Serve, bless, praise; see the good only. Express gratitude and love, even to the point of "adoring" one another.

If you are the one who is depressed or suffering from another mental health challenge, you may find it helpful to substitute "one another" in the passage above with the word "yourself" as you progress toward achieving recovery. In spite of the veil you may feel between your conscious self and your spirit, strive to love yourself, praise yourself, see the good in yourself, and be grateful to yourself for bearing up under your heavy burden. Try not to put yourself down, even though depression may be twisting your thoughts to the negative. Be kind to yourself. And at the same time, realize that it is no one's problem to solve but yours. That means recovery from major depression and other mental illnesses may be more or less a full-time job, and it may be one you will do for the rest of your life.

Taking responsibility for the illness is step number one. This does not mean believing that you caused the problem or that it is your fault. It means understanding and valuing your uniqueness while realizing that only you can create the recovery plan that will be right for you.

Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a large government organization in the United States that oversees a variety of mental health programs, research efforts, and policy recommendations. Recently, it released a new set of policy guidelines regarding mental health treatment that rejects the old medical model and embraces an individualized, self-determined, holistic approach. Recovery is defined as a process that encompasses an individual's whole life "including mind, body, spirit, and community" ("Recovery"). The guidelines state that "there are many different pathways to recovery and each individual determines his or her own way" (del Vecchio).

Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" ("Recovery"). The guidelines emphasize that recovery is real. No matter how severe and long-standing a mental illness may be, it is possible to create a plan that allows for a full and meaningful life. By taking charge of one's own illness and assembling medical help, counseling, skill training, nutrition, exercise, mind-body practices like yoga and meditation, and other curative practices, individuals become healthy and empowered.

Of course, various situations can make recovery more complex. A history of physical and/or psychological trauma requires specialized trauma-focused services by persons with training in these areas. A trauma history

can greatly complicate the already complex issue of recovery. Likewise, when addictive behaviors are part of the picture, they too require specialized treatment. Self-help groups aid recovery and emphasize that personal change is a life-long process of discovery that benefits from group support.

The recovery process is ever changing and may include setbacks and learning experiences that are painful. This is normal and should not be associated with failure or lack of effort or willpower. Setbacks are opportunities for growth. Small initial steps are often the most difficult, and when they do not result in the immediate alleviation of symptoms, many individuals lose hope and stop the process. It is important not to give up but to continue forward, adding more pieces to the recovery plan until the symptoms are under control and life is livable.

The new guidelines highlight that recovery is a way of life and the "experts" are those with the "lived experience" of healing. In the following story, Samila suffers from major mental illnesses and stigma. When her internal distress becomes too much to bear, she is faced with a choice. Her story shows how the supportive responses of others in her life enabled her to survive and begin her journey of healing while discovering the spiritual purpose of her life.

Waves of Acceptance

Samila (whose name has been changed for anonymity) is a woman in her mid-thirties whom I met at a Bahá'í conference on healing. She was a speaker who shared her recovery plan with the group. Despite having been diagnosed with major depression, anxiety with panic attacks, eating disorders, and borderline personality disorder, she reported that she is living a full and meaningful life. Samila has created a comprehensive array of resources and practices that she calls her "wellness plan." It includes regular visits with a psychiatrist, psychotherapist, and registered dietitian; physical exercise; interpersonal skill training using Dialectical Behavior Therapy; an active spiritual life; and participation in Bahá'í community activities. Samila created the plan herself. She explained, "We have to find the way ourselves because no one else is going to do it for us."

Samila agreed to share her story during a telephone conversation in August 2016:

> You are already fighting a battle every single day against your own brain, but it's worse to fight the stigma that you have put on yourself and that other people have put on you. I just remember the years and years I went without help because I was so afraid of being seen as damaged. I hid it. I didn't get the help I needed. I beat myself up for decades and just hurt myself so much mentally and emotionally. Those were circumstances that were largely set up for me by my parents, but

that was the only attitude they had ever known. You didn't talk about it. You certainly didn't acknowledge it. You moved forward. You distracted yourself. You just continued on as if nothing is really wrong. You can't say, "Something is wrong" because it's not your foot that hurts. It's your brain that hurts. People can't fathom that. It is a scary unknown beast. Everybody goes silent when you talk about it.

For over thirty years I lived with shame and fear and felt angry and bitter because these were the circumstances I was given. I thought, 'Why did I have to get this kind of life?'

When I had my breakdown a few years ago, it was the first time I contemplated suicide. I realized the things I was doing in my life made it impossible to live. I could not continue playing this game I had not signed up for. There were rules that had been imposed upon me, and I had no choice in them. I realized hey, if these are the rules and they mean I can't live anymore, I can't survive. I was never hospitalized. I was in my office at work when I had this realization. Later that day I was able to see my therapist. She made me sign a contract that I would not take my own life. I promised I'd go and stay with my parents and tell them the truth. That was the first time I ever told my parents I had these kinds of thoughts. It was terrifying. My mom sat by me and hugged me and cried and was just there for me.

It is three years now that I have been talking about my mental health. I am owning my mental illness and talking openly about it. I still get scared, but now it's my way of saving myself.

I used to say, "Why did I get this as my lot in life?" And the answer I got back from God was, "This is your purpose. You have been given this challenge so you could use it for some good." If I talk about this, maybe it will at least reduce some of the stigma, at least in my corner of the world.

Now I go toward the love—those who reach out to me and say either, "I struggle too," or they say, "I think you are so great and courageous," and others say, "I want to be there for people like you too." Whatever makes me feel seen and heard gives me hope, as the waves of acceptance flow out.

Conclusion

The goal of the preceding discussion has been to show that the application of the Bahá'í teaching of the unity of mankind is urgently needed in the field of mental health.

Depression is now the leading cause of disability worldwide and despite the fact that highly effective treatments are available, the majority of those who suffer do not get the help

they need. The stigma of mental illness is the greatest barrier to treatment. Stigma is a societal problem; a problem of attitude, of ignorance, and denial. It labels and blames those who suffer and greatly enhances their distress at the time when they most need love and support. It creates societal barriers that go unchallenged despite their glaring inequities and negative consequences.

Conversely, when communities recognize and welcome those who have mental health challenges like depression, they begin to create the framework within which the sufferers can heal while the community benefits from their presence.

As the many stories and examples illustrated, depression expresses itself uniquely within individuals and each healing journey is different. But all human beings benefit when the reality of the soul and the potency of supportive relationships are acknowledged. Interpersonal neurobiology shows how the mind depends on relationships for health and how transcendence itself is linked to the reality of love as it unfolds within each of our lives. Healthy individuals have a responsibility to examine their attitudes about mental health challenges, educate themselves, and take an active role in combating stigma through loving compassion towards those who suffer.

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