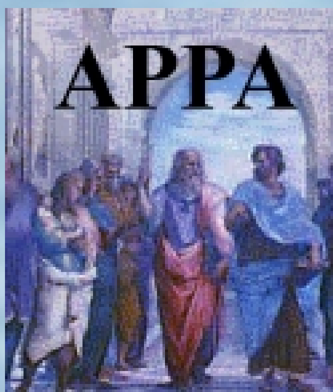

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Rethinking the Psychopathology of Depression

Existentialism, Buddhism, and the Aims of Philosophical Counseling

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Abstract

The instrumental classification of depression made possible by the Diagnostic and Statistical Manual (DSM) and the widespread pharmacological approach to treatment in mainstream bio-psychiatry has generated a cottage industry of criticism. This paper explores the potential shortcomings of the DSM/bio-psychiatric model and introduces the value of philosophical counseling—specifically by means of integrating the insights of Existentialism and Buddhism—as a way to overcome a number of diagnostic and methodological problems. Philosophical counseling, in this regard, is not overly concerned with the objective question of "What we are?" as biophysical beings with overt behaviors but with a more fundamental question, namely, "How we are?" that is, how do we experience our existence as finite, impermanent beings, how does this experience shape and determine depressive episodes, and how can we come to accept our own finitude and impermanence?

Keywords: *depression, psychiatry, DSM, existentialism, Buddhism, philosophical counseling*

Introduction

A growing number of physicians and psychiatrists are referring to ours as "the age of depression." The statistics, in this regard, are staggering. Today, depression, as described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), is ten times more common then it was a generation ago, and the age of onset has gone from thirty years of age to fifteen. The World Health Organization (WHO) has identified depression as the second biggest public health problem in the world just behind heart disease but ahead of cancer and AIDS combined. And there are now twenty-eight million Americans—one in every ten—who are taking some kind of anti-depressant. Indeed, eight of the ten most commonly used medications in the United States treat a condition that is directly related to chronic depressive stress including: anti-depressants, anti-anxiety medications, sleeping pills, and medications for gastric problems and high blood pressure. (O'Connor, 2006; Solomon, 2001)

In what follows, I want to suggest that philosophical counseling—unlike the pharmacological treatments characteristic of mainstream bio-psychiatry—allows the therapist to rethink the etiology and treatment of depression by interpreting it not from a biological or behavioral framework but from an existential framework, from how we live our lives in the twenty-first century. To this end, I want to suggest the integration of two philosophical schools that, combined, may overcome a number of the methodological and diagnostic problems that are becoming commonplace in DSM models of treatment. The integration is with Existentialism and Buddhism.

Although much has been written about the ontological and ethical affinities between Existentialism and Buddhist philosophy, particularly through comparative studies with Friedrich Nietzsche and Martin Heidegger, there has been little work done that brings the two together to address current issues in psychotherapy.[1] Of course, taken independently, the two traditions have a considerable legacy in the therapeutic disciplines. Heidegger's analysis of human existence (Dasein) in *Being and Time* (1927), for example, influenced a generation of prominent psychiatrists in Ger-

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many and Switzerland beginning in the 1940s including Ludwig Binswanger, Medard Boss, and Roland Kuhn, who formed the "Daseinsanalyse" movement which later developed into "existential psychotherapy," promoted by figures such as Rollo May, R. D. Laing, and Irvin Yalom (May, 1958: 3-36). And there has been a growing interest in bringing the insights of Buddhism into the mainstream of Western medicine. The most prominent example of this in the United States is undoubtedly Jon Kabat-Zinn's Mindfulness-Based Stress Reduction (MBSR) program at the University of Massachusetts' Medical Center established in 1979. This groundbreaking program employs the mindfulness meditation practices of Buddhism to address everyday stress, pain, and chronic illness as well as the emotional suffering that comes from cycles of recurrent depression and anxiety.

Both Existentialism and Buddhism, in this regard, resonate to what is unique to the practice of philosophy itself, specifically that philosophy—at least in its Greek and Roman inception—is not to be understood as a body of objective knowledge that can be grasped by a disengaged observer. Philosophy is, first and foremost, a practical activity, a path or way of living that concretely addresses the miseries of life.[2] To this end, philosophical counseling does not ask the diagnostic questions that make it possible for psychiatrists—using the latest version of the DSM—to classify a specific symptom or behavior in one way or another. Philosophical counseling is not concerned with the objective question of "What are we?" as biophysical beings with overt behaviors but with a more fundamental question, namely, "How are we?" that is, how do we live our lives; how do we experience our existence as finite, impermanent beings, and how does this experience shape and determine depressive episodes.

Depression and the DSM

The last twenty-five years saw the American Psychiatric Association (APA) turn away from psychoanalytically based diagnoses to a theoretically neutral and biological approach. This shift in orientation is embodied in the last three editions of the DSM—beginning in 1980 with the publication of the DSM-III and succeeded by the DSM-III R (1987), and the DSM-IV (1994)—which rigorously classified the various manifestations of mental illness and described a core number of observable symptoms that can be used to identify them. This new scientific methodology was thought to represent a significant break from the empirically ambiguous and unreliable classificatory principles of Freudian theory like the Oedipal complex, transference, and the nature of dreams that characterized earlier versions of the DSM—the DSM-I (1952) and DSM-II (1968). For Robert Spitzer, an influential advocate of bio-psychiatry and the primary architect of the DSM-III, this shift in orientation would overcome the embarrassing lack of diagnostic precision in the mental health professions by identifying diagnoses that were scientifically valid, reliable, and accurate.

The influence of the latest editions of the DSM is enormous. Not only is a DSM diagnosis now mandatory for reimbursement by insurance companies: Its methods, definitions, and diagnostic criteria are required for the acquisition of research funding from the National Institute of Mental Health (NIHM). Lawyers, school counselors, prisons, and social and welfare service agencies all refer to the manual to identify abnormality and culpability. It is, therefore, no surprise that the book can be found on the shelves of virtually every mental health practitioner (Kutchins and Kirk, 1997: 247).

However, for a growing number of social theorists, physicians, and psychotherapists (Kutchins and Kirk, 1997; Glenmullen, 2000; Healy, 2004; Moynihan and Cassals, 2005; Critser, 2005; Lewis, 2006), the instrumental efficiency of bio-psychiatry and the DSM has created an overly reductive, simplistic, and even dangerous approach to diagnosis and treatment, an approach that is leading psychiatrists to increasingly emphasize short-term symptom relief through the use of powerful psychotropic medication. The consequence has been an uncomfortably close relationship between the

pharmaceutical industry and the APA, with direct-to-consumer advertising for psychiatric medication, the industry's massive funding of psychiatric research, and the increasing presence of drug companies at professional meetings and conferences, resulting in what psychiatrist Paul Chodoff (2002) refers to as a "furor psychopharmacologus" (p. 628). These influences have led critics to question the assumption that the new versions of the DSM are grounded in the same objectivity and theoretical neutrality as the rest of the medical sciences.

Indeed, when it comes to the core issues of *validity*, *reliability*, and *accuracy* of diagnosis the latest versions of the DSM do not deliver what they promise. In the case of scientific validity, for instance, the American Psychiatric Association endorses the idea that there is a biological basis for depression. Yet, psychiatrists have yet to conclusively prove that any mental illness has a clear biological or genetic origin. Unlike other branches of medicine that can make valid diagnoses on the basis of biology, the psychiatrist cannot point to anything biological, a blood test, brain scan, or physical lesion that represents the cause of depression. The surgeon general's own report on mental health states that "the precise causes of mental disorders are not known" and "there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify (a mental) illness" (Hoeller, 2003). This failure to locate a clear biological cause for depression may explain why treating it with medication can be so frustrating for physicians and psychiatrists who are frequently faced with clients who respond to placebos as often as they respond to the actual medication or previous responders whose medication has simply "stopped working."[3] Without a genetic etiology, the DSM is reduced to relying on observable behavior, not biology, for diagnoses. Here, the problem of scientific validity dovetails into the problem of diagnostic reliability.

One of the goals of the DSM-III and its successors was to identify a set of clear and objective behavioral criteria to justify a given diagnosis in order to overcome disagreements concerning who was ill and what they were suffering from. This would result in scientifically reliable treatment because they would be based on consistent, replicable diagnoses. Yet, the DSM's own behavioral criteria for depression reveal anything but consistency and clarity. The DSM-IV, for instance, lists 9 symptoms for identifying a major depressive episode, 5 of which have to be met for at least a two-week period. These criteria include such ambiguous symptoms as: "feeling sad most of the day," "diminished interest or pleasure in things," "significant weight loss or gain," "fatigue or loss of energy," "feelings of worthlessness or guilt," and "diminished ability to concentrate" (APA, 1994: 327). These vague descriptions cannot be objectively quantified and, for this reason, can in no way be interpreted as scientifically reliable. It should come as no surprise that psychiatrists all-too-often disagree about what constitutes "diminished" interest, "loss" of energy, or a "significant" weight loss and how these symptoms may or may not map onto the illness of depression.

Finally, when it comes to diagnostic accuracy, critics like Herb Kutchins and Stuart Kirk (1997) have pointed out that in the age of the massive bureaucracies of managed care (MCOs), the DSM has become little more than a "management tool" used to "control client flow into and out of agencies." One therapist remarked, "If the DSM didn't exist, managed care would have had to invent it" (p. 256). Inaccuracy and misdiagnosis, in this regard, continue to plague the mental health professions today precisely because the client's unique experience of depression is forced into the faceless domain of health care cost containment. In this regard, the instrumental diagnostic criteria of the DSM may be helping to drive the financial interests of managed care by serving as a catalyst to the goals of efficiency, cost-effectiveness, and expediency.

What is obviously diminished in the objectifying framework of the DSM is the psychotherapist's ability to carefully engage the situated complexities of the client's own experience of depression. These complexities cannot be addressed by merely examining the client as a biophysical object with overt behaviors or symptoms. They can only be approached by means of an existential analysis

of the client's way of 'being-in-the-world', an analysis that pays careful attention to the client's existence, his/her engagement with family, work, social status, and the technological world as a whole. More fundamentally, this analysis explores the ways in which we—in the course of our workaday lives—actively cover over and deny the intuitive but painful awareness of our own finitude and impermanence. However, it is *only on the basis* of this awareness that we can begin to acknowledge the inherent fragility and tragedy of the human condition, that existence is not something that can be scientifically fixed or controlled like a broken arm or high cholesterol. It is in coming to grips with the fact that suffering is essentially woven into the human condition that we can begin to interpret the experience of depression in new ways. Here, we can turn to the insights of Existentialism for clarification.

Existentialism and the Role of Suffering

The central themes of Existentialism are familiar. Disenchanted with the rationalism and scientific optimism that characterized the Industrial Revolution, nineteenth-century philosophers like Søren Kierkegaard and Friedrich Nietzsche suggested that this historical shift left Western Europeans feeling emotionally fragmented, alienated, and empty. The scientific Enlightenment, in this regard, resulted in what Nietzsche called the "Death of God" because it destroyed the shared truths and values that gave pre-modern life a sense of enduring cohesion and purpose. With the Enlightenment, the natural world was no longer viewed as an enchanted garden, a "great chain of being" that humanity was indelibly interwoven to but as a vast and ultimately meaningless aggregate of material objects in causal interaction that could be quantified and controlled by various technologies. This brute, mechanistic worldview, combined with the growing influence of the Protestant ethic of individualism and self-reliance, manifested a sense of being disconnected, where human beings felt estranged from themselves, from others, and from nature.

The existentialists realized that the modern experience of isolation and emptiness could not be mastered by reason or by new technologies because the human being is, fundamentally, not a thing that can be controlled. We are, rather, a finite movement or span of life with no enduring permanence or stability. We are, to put it simply, no-thing. Indeed, for the existentialists, all the various social projects, relationships, and vocations that we embark on to create a sense of thing-like security can be viewed as attempts to cover over or flee from our own structural nothingness. Ernest Becker (1973) will later refer to these worldly techniques as "character defenses" that we employ to protect ourselves from the feelings of anxiety and dread that awaken us to the precariousness and vulnerability of being human (p. 23). Society in this regard, is largely structured to cover over and deny the nothingness that underlies all things.

The psychiatrist Irvin Yalom (1980) helps to apply these existentialist insights by interpreting them in terms of a dynamic approach to psychotherapy. The word "dynamic" here is used in the technical sense, referring to forces that are in conflict within each individual. This conflict emerges from an individual's singular confrontation with "the givens of existence," death and finitude being the most obvious. On this view, the conflict between one's desire for security and permanence and the intuitive realization that life is essentially insecure and impermanent manifests itself in anxious "boundary" or "border" experiences where the meaningful web of social relations collapses and we are left exposed in a region of raw meaninglessness (p. 8-13). The natural response to these experiences is to flee back into the comforting routines of everyday life, filling our own emptiness with various social diversions and distractions—work, shopping, movies, travel, eating out—that keep the anxious awareness at bay.

From the perspective of existential psychodynamics, when we flee from the despair of our own nothingness we replace it with something objective. In his essay, *The Concept of Dread* Kierkegaard (1957) explains: "The *nothing* which is the object of [anxiety] becomes as it were, more and more a *something*" (p. 55). In other words, despair in the face of nothing becomes fear of something— *of* flying, *of* public speaking, *of* crowds. Although inconvenient these objective fears can be managed and controlled. Despair, in this regard, "is always transformed into something less toxic for the individual; that is the function of the entire system of psychological defenses." (Yalom, 1980: 45) Existentialism reveals that the nothingness underlying my being cannot be controlled because it constitutes what it means to be human. Rather than fleeing from despair and displacing it into objective fears, existential psychotherapy seeks to draw the client's attention right to the source, to a sincere awareness of our own incompleteness and finitude. This awareness has the potential to release the client from old habits that keep despair at bay and open him/her up to major shifts in life perspective, seeing life in all of its fragile richness.

In response to the approach of mainstream bio-psychiatry that interprets these feelings of indifference and emptiness in terms of chemical imbalances and seeks to pharmacologically block them out, the existentialist approach asks the client to resolutely confront the feelings, to face them, because they are revealing core aspects of what it means to be human, specifically, that your life actually *is* empty and the universe *is* indifferent. Given this, there is nothing that grounds your being, and you are now free to choose and create the meaning of your life on your own terms, with a renewed sense of passion and intensity. The problem with the existentialist approach, however, is that, if taken on its own, it tends to promote a heroic and, according to some philosophers, overly masculine notion of health and authenticity. The authentic self—whether it is in the form of Kierkegaard's "Knight of Faith," Nietzsche's "Overman," or Heidegger's "Hero"—must be courageous and soldierly, willing to suffer in the face of the abyss. On this view, living a life based on secure and familiar social routines is inauthentic. Such a conformist life disburdens us from the painful awareness of who we are. Kierkegaard (1941) sums up the existentialist position in the following way:

"Out of love for mankind, and out of despair at my embarrassing situation, seeing that I had accomplished nothing and was unable to make anything easier than it had already been made, and moved by a genuine interest in those who make everything easy, I conceived it as my task to create difficulties everywhere." (p. 166)

From Kierkegaard's perspective, it appears that the only way to properly understand depression is to become *completely depressed*, to soberly experience the difficulty and pain of existence. The therapeutic rewards come only from persevering in the face of this pain, a perseverance that opens up the possibility for new ways of living that are not dictated by herd-like conformity. Nietzsche's *Gay Science* aside, existentialism has a tendency to glorify despair by recognizing it as the key to self-actualization. However, to those already in the throes of depression, these ideas are not very therapeutic. It is here that the tools of Buddhism are especially helpful.

Buddhism and the End of Suffering

Buddhism, like Existentialism, acknowledges the fundamental impermanence and emptiness of existence and the inevitable suffering that accompanies this awareness. But the goal of Buddhism is not to courageously face suffering but to put an end to it. Indeed, the teachings of Buddhism can largely be reduced to one core principle: there is suffering (*dukkha*), and there is an end to suffering. What is counterintuitive to Westerners, however, is that the Buddhist approach to ending suffering involves letting go of the need to defend ourselves from suffering in the first place.

On the Buddhist view, suffering maintains its power over us only insofar as we habitually regard it as threatening, as unnatural to the experience of being human (Batchelor, 1997: 7). The suggestion here is that we spend an extraordinary amount of time and energy either ruminating about our depression or consuming various products— medications, gurus, priests, and therapists—to keep depression at bay. But this desire to master and subdue depression does little to alleviate it. Thinking about it only makes it worse, the drugs may lose their effectiveness, the rush of the shopping, gambling, or traveling wears off and we inevitably return to where we started, to suffering. Indeed, on the Buddhist approach, the path to end suffering is not to subdue it but to simply become aware of it *as* suffering.

We can use the DSM's own criteria for identifying a depressive episode. The client who exhibits, for instance, symptoms of "fatigue or loss of energy," "feelings of worthlessness," or a "diminished ability to think or concentrate" is asked, by the Buddhist psychotherapist, to be *mindful*, to draw their attention right into these bodily sensations, into the fatigue itself, into the tightness in the chest, the knot in the stomach, or the fog in the head. "Mindfulness," in this regard, means deliberately "paying attention to things as they actually are in any given moment, however they are, rather than as we want them to be" (Kabat-Zinn et al, 2007: 47). To this end, rather than fleeing from the unpleasant sensations or courageously facing them, the client is asked to simply sit still and let them be as they are. Shunryu Suzuki (1970) offers the following example:

"Suppose you are suffering from a hopeless [despair]. You do not know what to do; you cannot lie in bed. Normally the most comfortable place for you would be a warm comfortable bed, but now because of your mental agony you cannot rest. You may walk up and down, in and out, but this does not help. Actually the best way to relieve your mental suffering is to sit in *zazen*, even in such a confused state of mind or bad posture… No other activity will appease your suffering. In other restless positions you have no power to accept your difficulties… When you feel [depressed] it is better for you to sit. There is no other way to accept your problem and work on it… When you are sitting in the middle of your own problem, which is more real to you: your problem or you yourself? The awareness that you are here, right now, is the ultimate fact." (p. 40)

Suzuki is suggesting that in the posture of *zazen* sitting, in paying attention to and accepting thoughts and sensations as they come, the client slowly recognizes that the feelings of depression—like all feelings—are not fixed and permanent; they come and go in waves. What Buddhism teaches, in this regard, is that it is by patiently staying with the thoughts and sensations of depression and breathing into them time and time again that the depression itself slowly starts to fade. "The Buddhist path," as David Loy (1996) explains, "[is] simple awareness… One does not do anything with suffering except develop the ability to dwell in it or rather *as* it; then the suffering, having nowhere else to direct itself, [slowly] consumes [itself]" (p. 57). The idea is that when we finally stop fleeing from despair and begin to accept it, the grip of despair is loosened. It is only when we respond to negative emotions with dread or aversion, regarding them as enemies to be defeated or overcome, that we get stuck in cycles of persistent despair (Kabat-Zinn et al, 2007: 36). The aim, in this regard, is to resist efforts to ruminate or think our way out of depression by constantly asking "What's wrong with me?" or "Why can't I be happy?" This familiar mental strategy to control and master our moods by thinking about them simply makes the condition worse.

Instead of thinking about our moods, the practice of mindfulness allows us to experience them immediately and directly through our senses. In these moments of bodily attentiveness, we stop dwelling on the *past* or worrying about the *future*; rather we pull ourselves away from mental rumination altogether and pay attention to what is happening right now. When we experience moods as they are rather than ruminating about them, existence begins to reveal itself in a different way, not as something to be controlled and fixed but as a mystery, a question. And the question cannot be

answered by means of any kind of rational introspection or mental strategy because you *are*—as a finite being on the way to death— the mystery, the question itself (Batchelor, 1997: 26).

In this regard, it is important to note that attentiveness to the sensations of depression is not a morbid exercise. As we draw the field of our awareness to the heartbeat, to the tightness in the back or neck, or to the rhythm of our own breath, we are awakened to the fragility of our own bodies and the precariousness of this life. With this attentiveness comes the realization that all of our worldly attachments—to our physical health, retirement portfolios, material possessions, friends and family—that create a stable sense of self is in no way enduring; all of life is in flux, a ceaseless emerging and withdrawing. Thus, there actually is no self. The only thing that is real is the present moment; this inhalation, this exhalation. To this end, the practice of staying with the movements of bodily sensations as they emerge and withdraw in the moment is the most appropriate exercise in realizing our own nothingness. The practice allows us to forget ourselves, our everyday worries and commitments, to become no-thing. The controlling grip that our worldly attachments has over our lives begins to loosen, and we are awakened to the extraordinary fact that we exist in the first place, and the inherent tragedy and transience of life is no longer experienced with dread but with awe.

There are, however, a number of issues regarding the integration of Buddhism that pose unique difficulties regarding its application to Western psychotherapy. The first involves a well-worn historical assumption concerning our interpretation of the self as an enduring, unchanging "substance" (*ousia*). Heidegger will trace this assumption back to Plato and Aristotle, who identify substance as the most fundamental category, one that refers to the essential being-ness that underlies all beings as beings. "[Substances] are," says Aristotle (1941), "the entities which underlie everything else, and…everything else is either predicated of them or present in them." (p. 5) The interpretation of the self as substance is consistent in the Western tradition from Hellenic Greece to the modern age. Heidegger (2005) explains:

"Since antiquity the *traditional conception and development of the problem of being* has been governed by the fact that *ousia* is comprehended as *substance*, or better, as *substantiality*: substance as the proper being-ness of a being… *Substantia: id quod substat* [is] that which stands under… The first structural moment is that which is preserved through all changes of properties and thus through the transformation of the thing, that which is fixed so to speak…*The innermost content of the concept of substance has the character of an enduring remaining, i.e. constant presence*"(p. 46).

What this understanding suggests is that we have a tendency to interpret the self as something 'real', 'constant' and 'permanent' that all-too-often lies buried beneath the superficial social masks that we wear in our workaday lives. The self, in this regard, is the core aspect of you, the soul, spirit, or mind that endures through any and all change.

This substance-oriented interpretation of the self took a distinctively modern turn in the 16th century with the Protestant Reformation. Reformers like Martin Luther—dismayed by the corruption of the papacy—shifted the emphasis of religious life away from shared works and practices to individual faith, promoting the Pauline Epistle that "The just shall live by faith [alone]" (Rom. 1: 17). Luther's rejection of the church hierarchy in favor of the principle of religious individualism amplified the notion that what is real and authentic is the 'inner' self whereas the 'outer' social world is viewed as corrupt and contemptible. The self, on this view, is no longer interpreted as something woven to a shared social fabric, to the cosmos, or to nature as it was in pre-modern times, but as an autonomous, encapsulated ego. Today, this individualistic interpretation of the self has been co-opted by various manifestations of pop psychology from Oprah to Phil ("Dr. Phil") McGraw. Dr. Phil (2001), for instance, describes his version of the authentic self in the following way:

"The authentic self is the *you* that can be found in your absolute core. It is the part of you that is not defined by your job, or your function, or your role. It is the composite of all your unique gifts, skills, abilities, interests, talents, insights, and wisdom. It is all your strengths and values that are uniquely yours and need expression, versus what you have been programmed to believe what you are 'supposed to be and do.' It is the you that flourished, unselfconsciously, in those times in your life when you felt happiest and most fulfilled." (p. 30, cited in Guignon, 2004: 2)

Existentialism and Buddhism regard the modern idea of a grounded individual self as an illusion. As we saw earlier, such an idea is merely a social and psychological construction employed to cover over and protect us from the anxious awareness of our own groundlessness, an awareness that reveals the unsettling fact that I am actually *not* real. This awareness poses special difficulties in the West because the assumption of a real, stable self has become so entrenched in our cultural institutions and practices. The strong sense of self in today's societies makes the anxiety that much greater when we are confronted with our *lack* of self. This is why, in an increasingly individualistic and secular age, we cling to our social identities—as professor, homeowner, husband, or American—because these identities create the illusion that I am some-thing. Without these identities that sustain our sense of self we are no-thing; we are left to face the abyss alone. Yet, it is only on the basis of letting-go of the self, of becoming a lack rather than manically fleeing from it, that we can begin to extinguish the source of our own suffering.

However, the need to disentangle ourselves from the manic defenses that shelter us from nothingness reveals a further difficulty when it comes to the Western appropriation of Buddhism. This has to do with the unique velocity of modern life itself. Life, in a turbo-capitalist economy, is increasingly lived at a harried and manic pace. This makes the Buddhist practice of mindfulness particularly difficult. The level of patience and commitment conflicts with the expectations of immediate results and quick pharmaceutical fixes that we are accustomed to in an accelerated, technological age. For instance, one of things that makes Kabat-Zinn's mindfulness program so difficult is that it is an eight-week course that requires a disciplined commitment of at least an hour a day of meditation or yoga, and it does not end there. The practice is to be carried out for the rest of one's life. The reason for this is that we are, all too easily, pulled away from mindfulness and back into the manic, ego-driven social projects and distractions that cover over our own nothingness. Indeed, Heidegger (1962) goes so far as to suggest that fleeing from nothingness is a structure of modern life itself, and we cannot help but "fall prey" (*Verfallen*) to these familiar and reassuring social distractions (p. 219-224). When we are accelerated, scattered, and dispersed in this way it is especially difficult to sit still and be mindful. Indeed, mindfulness can be frightening precisely because it is so unfamiliar to our frantic, over-committed lives.[4] Fearful of stillness, it is easy to reply to the therapeutic recommendation of mindfulness practice with the response, "I'm too busy" or "I simply don't have the time." It is this kind of response that takes us back to the fundamental aims of philosophical counseling.

Mindfulness, Modernity, and Philosophical Counseling

Again, the original Greek and Roman interpretation of philosophy was understood in terms of *praxis*, a practice that was concerned primarily with living an integrated, well-balanced life. Philosophical practice—from Socrates to Seneca to Epicurus—has always been concerned with exploring concrete ways of living that engage the invariable suffering of human existence. Philosophical counseling, in this regard, is unique as a therapeutic discipline because it is concerned, first and foremost, with the client's way of living, prior to any objectifying or theoretical framework. This allows philosophical counseling to ask a different set of questions when it comes to depression. It

does not ask: "*What* are you feeling?" "*What* are your symptoms?" Such questions operate under the assumption that the human being is a bio-chemical thing with quantifiable attributes. Rather, philosophical counseling understands that depression emerges as our lives unfold in specific socio-historical situations. To this end, philosophical counseling asks: "*How* are you?" Or, more specifically: "*How* do you live your life everyday and for the most part?" It is on the basis of this question that we can get a different sense of the etiology of depression.

This is how I—and perhaps many American academics—would respond to the philosophical counselor's question.

On any given weekday, I get up at 7:00 AM to a loud alarm clock after too few hours of sleep, quickly take a shower, get dressed, drink two large cups of coffee, and grab a bagel on my way out the door. I then drive for twenty minutes in heavy traffic to the university, listening to the news on the radio. Upon arriving at the office, I immediately check and reply to any e-mail. I then go over my notes and walk to class to teach for an hour. If I don't have another class, the rest of the day is given over to a busy succession of meetings, questions from students or colleagues, more e-mail, and hopefully, in the late-afternoon, some closed-door time when I can work on my own research. Usually, it is dark by the time I drive home, and I get ready to begin the cycle again.

Initially, there is nothing too distressing about this account. The only thing that stands out is that it conflicts a bit with the assumption that the life of an academic is supposed to be appreciated for its leisurely pace and abundant time for quiet reflection. But upon closer examination of the question: "How do you live your life?" it begins to closely resemble Heidegger's notion of "falling prey." I too am busily scattered in worldly attachments with little or no awareness of what this harried way of life is doing to me, and how it is affecting my moods, my posture, my digestion, and my sleep. Indeed, a number of psychotherapists are beginning to suggest that it is the unique velocity, busy-ness, and over-stimulation of modern life itself that is the most significant contributor to the onset of depression. Psychotherapist Richard O' Connor (2006) explains:

"For an overwhelming number of people today, the result is a state of permanent malfunction—dissatisfied, irritable, overwhelmed and hopeless, out of control, frightened, physically run down and in pain. For want of a better term, this is what I call the 'Perpetual Stress Response.' The many other labels for this state depend on how the victim perceives the condition or which healer the patient consults for it. Is it depression, anxiety, chronic fatigue? Is it a neurological, endocrine, mental, emotional, spiritual problem? My answer is yes—it's all of these, and more." (p. 21)

The suggestion here is that depression is by no means a clearly defined disorder. Depression occurs in terms of a sliding scale and affects almost everyone to a certain degree who labors in a technological economy because the human nervous system has simply not been able to adapt to the workaday stress and stimulation that it is now subjected to. This is why depression is rarely an isolated condition and is often accompanied by other stress-related pathologies like insomnia, anxiety, chronic fatigue, irritable bowel syndrome, high-blood pressure, and lower back and neck pain.

O' Connor's argument is fortified by the sheer ubiquity of the use of words like "stressful" and "busy" to describe our everyday lives and the increasing tendency to interpret these words positively. Today, it is simply assumed that one is stressed out and overwhelmed. Existential philosophers, in this regard, played a key role in challenging the alleged progress of increasingly mechanized and automated ways of living by identifying a number of new stress-related mood conditions that were beginning to emerge in metropolitan areas in the late nineteenth and early twentieth centuries. Careful analyses of *anxiety* (Kierkegaard), *boredom* (Heidegger), *anomie* (Durkheim), and *alienation* (Marx) emerged for the first time, becoming core signifiers that captured the misery of a harried and emotionally fragmented existence.

One of the goals of philosophical counseling, in this regard, is to question the taken for granted ways of life that manifest these conditions and interpreting them not as individual pathologies but as by-products of socialized expectations and practices that are unique to modernity. Thus, unlike the DSM model, philosophical counseling does not pathologize depression as an individual disease but considers it within a wider lived-context, a context that is so close to us that we are largely unaware our own involvement in it. Mindfulness is crucial precisely because it allows us to momentarily break from the frenzied cycle of our workaday lives by turning the field of our awareness away from the overwhelming distractions, choices, and commitments to the simple rhythms of the body and the breath.

To this end, mindful attentiveness to the body is a holistic therapy that is not only effective on mental conditions like depression, obsessive-compulsive disorder, and anxiety but to the physiological miseries of fibromyalgia, chronic pain, bulimia, psoriasis, and stress symptoms in cancer patients. The reason for this, from the Buddhist perspective, is that the mind or self is in no way separated from the fragile rhythms of our physical body. By focusing on the subtle movements and sensations of the body we begin to understand that our mental suffering, like the body itself, is not fixed but transient and finite. This awareness highlights one of the more serious diagnostic problems with bio-psychiatry, namely, the interpretation that depression emerges primarily from an innate genetic or bio-chemical source. Such an interpretation gives depression an aura of permanence, and because of this, patients are often told they will always be susceptible to depression and must take psychotropic medications for the rest of their lives.

However, because of its flexible and pluralistic orientation, philosophical counseling would not dismiss the value of anti-depressant medication. Indeed, in my view, philosophically inclined psychotherapists would strongly support the use of anti-depressants in conjunction with mindfulness practice, pointing out that mindfulness alone will do very little for someone who is suffering from a major depressive episode. Anti-depressants, in this regard, can initially relieve the crippling symptoms and can allow the client to begin the practice. Philosophical counseling, therefore, would not question the fact that there is a biological, brain-related aspect to depression, but this is not the single cause regardless of the reductionist assumptions of mainstream psychiatry. As biological beings, we are already thrown into an overwhelmingly complex and accelerated world, and this world invariably shapes the structure of the brain. And there is growing clinical evidence that practices like meditation do the same thing, rewiring the brain by creating new neural pathways that restore brain centers to their more natural state (Bishop, 2002; Carlson et al, 2003; Kabat-Zinn, 1982; Kristeller and Hallet, 1999; O' Connor, 2006; Speca et al, 2000; Teasdale, 1999).

To this end, by integrating the insights of Existentialism and Buddhism with philosophical counseling, we are allowed us to ask more fundamental questions concerning the origin of depression. Existentialism recognizes the First Noble Truth of Buddhism, namely that "to live is to suffer." This means we will all experience depression in different degrees at different points in our lives. This is not a disease; it is what it means to be human. And, in our fragmented, over-committed lives, it is becoming more intense and pervasive than ever. The value of Buddhism, in this regard, is the identification of a living practice that can begin to release us from the grip of toxic stress and busy-ness by patiently and repeatedly drawing our awareness right into the simple sensations of the body, an awareness that can quiet the mind in the midst of the uproar and allow us to see that depressive emotions and thoughts, like all things, come and go.

Notes

1. The notable exception in this regard is David Loy's pioneering book *Lack and Transcendence: The Problem of Death and Life in Psychotherapy, Existentialism, and Buddhism*. New York: Humanity Books, 1996.

2. As Heidegger (1956) says, "…the Greek word *philosophia* is a path along which we are traveling." (p. 29). See Robert D. Walsh (2006: 497).

3. Here I am indebted to conversations with psychiatrist Phil Sinaikin and his unpublished manuscript "Bored to Tears"

4. Nietzsche (1997) puts it nicely when he writes: "Haste is universal [today] because everyone is in flight from himself… But what is it that assails us so frequently, what is the gnat that will not let us sleep… We are afraid that when we are alone and quiet something will be whispered into our ear, and so we hate quietness and deafen ourselves with sociability." (p. 158-59)

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