A Depression Managed by A City Manager

Balancing Life's Personal and Professional Interests

Mark Sowa

What is clinical depression? What are its symptoms? Can it be treated? Can I work? Will my life return to normal?

As if he could read my thoughts, the psychiatric physician used his skills to answer my endless list of questions and comfort me as I faced this painful illness.

"Unlike psychological depression, which may have numerous mental causes, clinical depression is a depressive illness caused by a chemical imbalance in the brain," he explained. "It also is known to be passed on genetically. One in 10 adults in the United States will experience clinical depression or will know a close friend or family member with this prevalent illness."

I winced at the frightening possibility that my two sons someday could go through what I was experiencing now. The feel of raw depression was haunting and relentless. In addition to a constant uneasy sensation of anxiety, its symptoms and side effects seemed to be at least 80 percent physical, including incredibly low energy, difficulty in sleeping, and an ever-present "stuffy" headache.

The physician continued, "Clinical depression, if not diagnosed early, reduces personal and business activities to a difficult state and clouds relationships with pain and confusion. It also can trigger irrational thinking and actions." I nodded at his mention of the critical importance of an early, correct diagnosis. Another physician's misdiagnosis of "anxiety," just weeks earlier, had complicated my recovery process greatly.

"Unfortunately, we have no failproof method of mea-

suring the existence or severity of depression," explained my doctor. "There also is no way of knowing which one of the many antidepressants will work best for an individual, other than prescribing by trail and error. The process is complicated by the fact that each time a change is made, a three-week weaning off the old medicine is required, and a buildup of the new medication is needed for a similar length of time. During these interim periods, patients may be prone to fall into an even deeper depression, making recovery therapy attempts extra-difficult."

The doctor smiled warmly. "At these times, you will be especially grateful for the therapeutic counseling received and for frequent support meetings, where strength and encouragement can be drawn from others who have walked where you are walking.

"Remission is the result sought from treatment," the doctor assured me. "That is the term used for 'wellness' or 'correction' of the illness. A patient continuing on an antidepressant may keep some side effects, yet normal lifestyle functions come back. As that happens, medications can be eliminated gradually, usually six months to a year later."

Getting to Know My Enemy

My wife and I left the doctor's office that day determined somehow to conquer the enemy attacking me. In bookstores and libraries, we looked for recommended medical references and books that would aid us in our understanding of the illness. These resources were useful for our own preventive education about the illness and for explaining to my family, friends, and coworkers what I was going through.

Some of the suggestions I read for combating stress were so practical that they seemed simplistic. Yet I had neglected to view as opportunities many of these basic procedures—balancing family and work life, setting priorities, keeping physically fit with regular exercise, and approaching life's personal and business problems positively. Each of these elements has its own place and is a necessary member of the depression recovery team.

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My reading continually underscored the fact that, at minimum, two factors are necessary for recovery. First and most important, an individual should seek a qualified doctor and begin treatment as soon as the problem has been detected. Without a doctor, antidepressant medication cannot be prescribed, and real clinical depression cannot improve. A second basic requirement for recovery is to identify an effective antidepressant for the individual. Without the correct antidepressant, clinical depression will not be treated successfully. The patient can be stuck in a mode of slight improvement, feeling a false sense of happiness and relief that a permanent "cure" has been found. Although this positive feeling is good, the patient should beware the long-term negative effects of this minimal change.

In reading about clinical depression, I was relieved to discover that some of its symptoms were the same as those sabotaging my day-to-day ability to cope:

1. Severe morning crying, lasting often into midday. Although my periods of weeping generally stopped before evening, the dread of a recurrence the next morning helped cause lack of sleep, stress, and all-night worry.
2. Thoughts of suicide as a means of stopping the pain. An individual may not attempt or seriously consider suicide as an alternative. However, the pros and cons of suicide occasionally may surface in his or her thoughts as part of the ongoing rationalization and search for the reasons for the illness. Recurrence of these thoughts worsens the depression.
3. Deep headaches.
4. Combination of low self-esteem with a tendency to blame problems on work or family.
5. Frequent morning diarrhea from a nervous stomach.
6. Weight loss or gain. In my early illness, I experienced severe weight loss, followed by marked weight gain. The need to diet overlapped with other recovery activities and disciplines, presenting a difficult additional problem.
7. Urinary impairment.
8. Upper-body rash and itching.
9. Extreme sleep reduction. During most of my illness, I got only about half as much sleep as I usually required.
10. Decreased energy, to the point of feeling too sluggish to function.
11. Periodic panic attacks.

The Rough Road to Remission

The 15-month nightmare I endured before remission actually was on the short side, compared with the experiences of others. Many patients continue to experience some level of depression for years or even for a lifetime.

Because my illness had been complicated from the beginning by misdiagnosis and by the prescription of an incorrect but powerful medication, I needed a four-day, "cold-turkey" withdrawal period. As the most effective medication and treatment program was sought for me, six different antidepressant medications were prescribed within a 14-month period. True to the doctor's warning, each change in medication was accompanied by deep emotional valleys in the transition periods.

During the course of treatment, I was hospitalized twice for one-week periods, received therapeutic counseling, and attended frequent group meetings. I also conducted a deep, honest spiritual inventory and began my first regular program of study and prayer—one side effect I desired to keep for the rest of my life.

Looking back, I now see clearly how my failure to blend family needs with business, along with stress from my "workaholism," contributed to the onset of depression. My form of workaholism was unrelated to office hours and was motivated positively. Because I relished the creative projects, challenging business responsibilities, and pleasurable working environment I enjoyed with my staff and the city council, I failed to recognize my limits, set wholesome boundaries, and take time for healthful diversions. I literally did not see life beyond the job at hand.

Public Exposure

Coping with this illness as a chief executive in local government presents a major problem that, in some situations, can be virtually impossible to resolve. Because it is human nature to be sensitive about public prominence, people often take deliberate actions to avoid any public exposure beyond the basic requirements of their jobs. It is easy to overreact by assuming that the public perceives every decision and action to be influenced by depression. However, this conclusion, which involves flawed perceptions of others' perceptions, only compounds the problem. Nevertheless, depressed people likely will struggle through many daily relationships and activities fully convinced of the reality of their faulty perceptions.

This kind of oversensitivity about clinical depression and all of its ramifications is exactly the wrong emotion to aid in recovery. At first, I permitted the problems to "hide" me, rather than allowing conversations on such subjects as my insecurity, fear, and indecisiveness.

The problems I had when public attention focused on me usually were characteristic of the problems of public officials in general. From time to time, various stories and assertions appeared in the local and metropolitan newspapers. Local political critics took advantage of my illness to peddle unfounded allegations on both the personal and business levels. Some of these individuals—not understanding clinical depression to be an illness and supposing that my absences at work, changes in behavior, etc., had to be signs of something suspicious—even spread allegations of drug and alcohol abuse. This con-

Myths and Facts About Clinical Depression

MYTH: Clinical depression is a character flaw, a sign of personal weakness.
FACT: Clinical depression is a medical illness.

MYTH: A person can relieve depression through prayer and willpower.
FACT: Mild depression may disappear with time, but if the illness is severe enough to decrease a person's ability to function beyond two weeks, treatment is recommended.

MYTH: Clinical depression does not really affect a person's everyday life; he or she just appears unhappy.
FACT: Clinical depression may profoundly affect individual functioning, social relations, and life-course.

MYTH: Clinical depression is no excuse for missing work.
FACT: Although clinical depression is rarely the reason given, absenteeism is one of the costly outcomes of untreated depression.
FACT: The person with clinical depression does not lack personal motivation or character; he or she has a medical illness. The illness can be treated with medication, therapy, or a combination of both.

MYTH: So what? Nobody dies from feeling blue.
FACT: Approximately 15 percent of people with severe clinical depression will commit suicide.

Source: Excerpted from DOWNTIME: A Worksite Guide to Understanding Clinical Depression, *1993. Used with permission from Wellness Councils of America, Omaha, Nebraska, 402/572-3590.*

stant pressure fed my fears of losing my job and depriving my family of the financial security and quality of life we had come to enjoy.

On the other hand, confidential communications from other city employees, plus cards and phone calls from friends and dozens of previously unknown well-wishers (many of whom either had suffered from depression themselves or told me of friends and loved ones who had), exerted a positive, faith-restoring influence on me throughout the experience.

The Balancing Act

At first, the depression had seemed to envelop me spontaneously. Later, as remission began, the renewed feeling of health and wholeness surfaced so thoroughly that I wondered why I was ever "down."

Like most local government managers, I could handle multiple services and issues. But keeping positive business energy moving toward an organization's goals involves some juggling and a lot of balancing.

A person's own physical and emotional health requires some juggling and balancing as well. People who want to avoid things crashing down around them must learn to achieve the proper blend between their family/personal lives and their business lives. This concept is not new. It is referred to often in business literature as part of stress management. Yet for me, managing stress is only the maintenance of a less-than-corrected, ongoing condition that can be minimized but rarely alleviated.

I believe that as local government managers, we must recognize the big picture for the well-being of our families, employees, and communities: we often must give priority to personal needs over work demands. We must use our professional training to become more forward-thinking and to plan for positive change in our lives. After all, if we can manage to do this under job pressure in the "fishbowl," can we not also achieve a formula for our total lives?

A Friend in Disguise

Clinical depression does not have to be only the enemy that derails our careers and personal lives. It is that at first. But in years to come, we may find behind its menacing mask the face of a friend. Why a friend? Because it forced us to relate more honestly with ourselves and to sort out our priorities. Because it taught us to put our planning and administrative skills to work around the clock—not only as a workaholic but in the totality of our lives. Out of the battle with depression, we can emerge healthier, stronger, better persons and leaders than before. And if we are unafraid to show our scars, we who have been wounded can encourage others to find healing. PM

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Signs of Clinical Depression in the Workplace

Employees who are clinically depressed may display one or more of the following symptoms at work:

- Difficulty in making decisions.
- Decreased productivity.
- Irritability and hostility.
- Withdrawal from others or, conversely, extreme dependence on others.
- Feelings of hopelessness or despair.
- Slowness of speech; chronic fatigue.
- Slumping posture; flat or blank facial expression.
- Inability to concentrate; decline in dependability.
- Unusual increase in errors in work-product.
- Proneness to accidents.
- Tardiness; absenteeism.
- Lack of enthusiasm for work tasks.

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Populations at Risk for the Illness

- Nearly one in 10 Americans in a lifetime.
- Persons aged 25 to 44.
- Females (diagnosed more often).
- Those with a family history of depression.
- People under great stress.

Types of Clinical Depression

- Major clinical depression.
- Bipolar disorder (manic-depression).
- Seasonal affective disorder (SAD).

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