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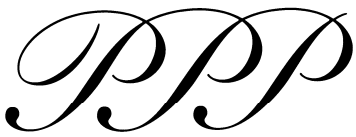
Truth and Healing a Veteran's Depression

Mike W. Martin



Keywords: depression, evolutionary psychology, ethics, Christopher Bailey

In "A Painful Lack of Wounds," Dr. Christopher Bailey portrays an American veteran, Colin, who slips into a "serious but not severe" depression upon returning from the Iraq War. After ruling out post-traumatic stress disorder, the psychiatrist comes to believe that Colin's depression is tied to his feelings of being a wimp, of not having "done his part or proven his manhood," and of losing his chance to become a hero because he had been assigned non-combat duty—feelings that the psychiatrist glosses (misleadingly?) as a "painful lack of wounds." (I speak of the "the psychiatrist," rather than Dr. Bailey, in case some details of the case are constructed.) The psychiatrist links Colin's feelings of failure with insecurities about his masculinity and about being able to defend himself and his family. Invoking evolutionary psychology, the psychiatrist suggests to Colin that his depression may be linked to how our culture continually activates "visceral alarm systems" that evolved on the African savannah, while providing insufficient outlet for their expression—a dynamic that might be especially damaging to the mental health of white men like Colin and himself. In response to Colin's questions, the psychiatrist affirms the martial arts while emphasizing prudence in expressing aggression.

I have four sets of questions and comments. First, does the psychotherapy succeed? We are told Colin is receptive to undertaking a course of talk therapy, but we are not told whether the therapy lifts the depression and has additional benefits. This information will color what we say about the psychiatrist's diagnosis and therapeutic approach. If the therapy succeeds, we might applaud the psychiatrist for avoiding a knee-jerk resort to pharmaceuticals, and laud his brilliance in framing Colin's suffering by invoking evolutionary psychology.

If the therapy fails, we might ask why psychotropic medication was not offered as an option, in conjunction with the talk therapy. We might also question whether the source of the depression has been pinpointed. For example, was Colin's *shame* about his non-combat duty the crux of the matter, or would a deeper examination reveal an underlying survivor *guilt* in watching friends die without being put at personal risk? Or was the catalyst of his depression simply the huge letdown in returning from exciting military service to the boredom of civilian life, perhaps to a job that has little challenge and a marriage that has lost its spark? Was invoking the African savannah an unhelpful digression? And was the psychiatrist counterproductively overidentifying with Colin as a white American man enthusiastic about the military arts, in need of more outlets for aggression, and worrying about his family's safety?

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Second, assuming the therapy succeeds, why does it succeed? Is it because Colin's brain chemistry is altered, which can occur through psychotherapy as well as pharmaceuticals? Or is it because of attitudes Colin develops during therapy? More broadly, has the psychiatrist spotlighted a neglected syndrome and helped us understand how to understand and treat it? Does research into the syndrome warrant funding (a moral matter because the research might deflect research funds from other worthy projects). Is there any reason to think this is mainly a white-male problem, or should we revisit Freud's views about society and human aggression in *Civilization and Its Discontents* (1930/1961), or instead invoke a feminist analysis about socially instilled ideals of masculinity?

Third, what is the role of truth in this very practical activity of healing? I share the now standard view that both brain chemistry and the patient's sense of meaning are important in healing depression. I also believe that both should be wedded to the "common factors approach" to understanding therapeutic efficacy pioneered by Jerome and Julia Frank (1991, 40–44), among others. The Franks ask how hundreds of different therapies can be effective in dealing with depression and other ailments, at least for some patients. They answer that healing turns on a combination of generic factors such as an emotionally charged extended relationship between a suffering client and a caring therapist, a safe setting in which the client can open up emotionally, some sort of explanation (not necessarily true) of the client's symptoms, and some type of procedure that the client and therapist think will help.

The common factors approach does not mean that a search for truth is replaced by just any subjectively meaningful encounter and perspective. But it does raise questions about the claims of insight therapies to cure by identifying "the" truth, as well as questions about how therapists sometimes distort truth as part of the healing process (Martin 2006, 163–166). Thus, evolutionary psychology might turn out to be irrelevant in explaining Colin's depression but still make a healing contribution when invoked by this particular psychiatrist interacting with this particular veteran (in contrast, say, with a pacifist counselor interacting with a biblical fundamentalist).

Fourth, and in conclusion, the case raises enduring issues about how far psychotherapy is and should be value neutral (Sadler 2005; Tjeltveit 1999). One issue is the extent to which therapists should express their personal values during therapy. If Colin's therapy succeeds, we have a case where the therapist's active discussion of values, in particular concerning male masculinity and the martial arts, plays a positive role. If the therapy fails, we have a case where the therapist's insertion of his values is inappropriate.

Another issue is how extensively psychotherapy is an inherently moral enterprise in which a caring and competent healer seeks to alleviate patients' suffering and help clients to grapple with life's challenges. These questions about therapeutic efficacy are not merely technical matters, but instead have moral dimensions. In addition, psychotherapy involves moral values in its procedures, such as respect for clients' autonomy and values, but also concern for third parties. With regard to third parties, the psychiatrist expresses worries that Colin's preoccupation with proving himself might in some situation "unwittingly put himself and his family in harm's way, if not hurt someone who was never really a threat to begin with." This is good therapy: helping the patient while keeping in mind the moral claims of family and community—indeed, linking them.

Still another issue is the extent to which moral values shape the very definition of mental disorders and mental health. As a society, we have come to define virtually all forms of suffering that disrupt morally desirable functioning as pathological. Conservative social critics are deeply alarmed by this trend, and might even question whether Colin's depression is sufficiently severe to be a psychiatric matter. Certainly there are grounds for caution about how far we have gone in medicalizing depression, but I see wisdom in the trend, assuming we appreciate how morality and mental health are interwoven dimensions of both mental disorders and strengths (Martin 1999, 2006).

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