

The bright side of being blue

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In a 2009 review, Andrews and Thomson propose an analytical rumination hypothesis which states that depression may be adaptive in that: [a] it gives the triggering problem priority access to processing resources, [b] reduces the desire to engage in pleasant activities that would compete for processing resources, and [c] produces psychomotor responses that reduce exposure to distracting stimuli.

If all you read was the title of the article, you might very well say: what? You have got to be crazy! Understandably, a proposition that depression is good for you, henceforth named BSBB (the Bright Side of Being Blue), is highly likely to trigger a disbelieving response in readers. I posit that such a knee-jerk dismissal is driven by a belief that we will not be able to convince our patients of that, and that, if this claim is true, therapy will no longer be needed and we are shooting ourselves in the foot. I also believe both fears are unnecessary, and I will argue in support of BSBB, with some notable qualifiers.

Before explicating why BSBB is not a threat to current understanding and practice, I want to direct attention to a major problem with this proposition, which, however, in the final analysis and conclusion is still not fatal, whereas it does call for qualifiers.

I applaud Andrews and Thomson (2009) for the wide net they have thrown for extricating relevant literature and for anticipating challenges to their ideas, as well as for the attention they pay to arising paradoxes. Many of the ideas supporting BSBB are not new (Klinger, Barta, Mahoney et al., 1976), nor do these authors take undue credit for them. The evolutionary explanation is utterly convincing: emotions help us adapt even if they feel acutely unpleasant (or else, we would probably be extinct). Research has shown that effortful suppression of the cognitions that reflect processing of affect does not work (Levenson, 2003), and this insight gave rise, in good part, to Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond et al., 2006), which I find remarkably complementary to the BSBB proposition. Other persuasive, well-supported arguments for BSBB are that the temporary reduction of hedonistic activities frees up processing capacity for an overload of negative affect. Furthermore, depression (when defined as a withdrawal from external stimuli) allows chunking of complex problems into little steps for faster processing. This latter point, of course, is also addressed elsewhere, namely in time management strategies (Linden, 2005).

Among the seeming paradoxes of a BSBB proposition is the observation that depressed people have shown superior performance on certain cognitive tests. I don't dispute this; however, the problem here is the implied linearity of the relationship between performance and depression, whereas I see this issue as very much like the Yerkes-Dodson model of anxiety and test performance (Teigen, 1994). Complete lack of anxiety is not associated with best test performance, and neither is very high anxiety, whereas performance is best with moderate levels of anxiety. Furthermore of note is that the performance-enhancing role of anxiety is particularly true for fast-paced but simple tasks, whereas performance on more complex tasks is more easily interfered with by test anxiety. Similarly, I argue that the relationship of cognitive performance to level of depression is also non-linear. Granted, this proposition has not really been tested, because patients with very severe depression are unlikely to make it into research studies as they will not volunteer, have too many co-morbid problems to meet eligibility criteria,

and cannot be motivated to complete cumbersome research protocols. Randomized controlled clinical trials are great for theory development, but they are of limited value for clinical practice because they do not fully reflect clinical reality where co-morbidity is normal, where patients have few resources, and where the typical patient is not a ready-to-change YAVIS client (Lichstein, Riedel, & Grieve, 1994; Walwyn & Wessely, 2005). In a related fashion, animal models of depression are of limited value because they do not deal directly with affect cognition interactions. All of this leads to the conclusion that Andrews and Thomson (2009) have fabricated a spider's web of strong interconnected arguments that is, however, most relevant for 'the worried well' and does not account for other depression facts. In patients with severe, longstanding clinical depression, it becomes impossible to discern whether the severe depression accentuated their life stress or vice versa, and we must assume that neuroendocrine abnormalities are prominent in the determination of behaviour. The latter point is well-documented in a meta-analysis showing that serotonin reuptake inhibitors are barely superior to placebo for low- to mid-grade depression, but are much more powerful and clinically useful for severe depression (Fournier, DeRubeis, Hollon et al., 2010). Moreover, Andrews and Thomson do not explain how suicidal ideation fits into this proposition; surely they wouldn't associate suicide with the term 'adaptive'.

We also do not hear them explain how some people may actually solve their problems via a temporary retreat, whereas others remain stuck. Is this like quitting smoking, where the best quitters never talk to clinicians and don't tell us about their successful strategies and tricks (Schachter, 1982)?

Can we convince our patients of the usefulness of a BSBB model? As much as psychologists are apt to dismiss BSBB or find it frivolous in light of patient suffering, it may seem an even harder sell when it comes to convincing our patients. In my clinical work, however, the model has been easy to apply. I typically see cardiac and cancer patients for whom a sometimes difficult emotional adjustment is secondary to the physical disease and its inherent threats. These patients are often shocked, and sometimes even numbed, by the strength of their emotional reactions.

When I inform them that emotions (even the negative ones) are adaptive in an evolutionary sense, they are relieved and find it easier to turn off self-blame. I describe anxiety as an important protective emotion in that it is highly adaptive to be scared of chainsaws or excessive speed while driving. A depressive mood can be easily reframed as a period of reflection, trying to understand how the disease came about, ask some existential questions about life's meaning, consider necessary lifestyle changes, and then gradually move on. Even anger can be described as useful, in that it can motivate others to follow one's wishes, keeping in mind that frequent use of anger with spouses or friends is likely going to backfire and ruin the relationship because social partners see it as manipulative (Gottman & Notarius, 2000). Moreover, I also describe these same emotions as deleterious if one does not get a grip on them within a reasonable time period. Once patients understand and accept their emotions, they are noticeably more ready and willing to learn about the conditions under which anxiety, for example, is self-protective and, inversely, when it is a shackle. Similarly, depressive mood can then be framed as destructive if allowed to go on for too long.

Do we make ourselves unnecessary if we support BSBB? When reading the article by Andrews and Thomson, I particularly watched out for disparaging remarks about professional therapy; I did not find them. Instead, BSBB is at least compatible, if not inviting and supportive, of ACT and CBT, and - I think - is also in line with the goals of interpersonal therapies. Andrews and Thomson (2009) themselves explain that it is adaptive to accept emotions and maladaptive trying to avoid them and, in so doing, they distinctly validate the very foundation of ACT.

In transferring BSBB ideas to clinical practice, the catch is to identify how long depressive mood can last and still be adaptive. This is akin to understanding grief reactions, which are considered normal unless overly long. Along these lines, I partly support Thomson and Andrews's argument that not spending time on hedonistic activities while depressed may allow extra time and effort for processing complex affective responses. However, this feature also benefits from a time limit, in that hedonic activities are badly needed to serve as buffers against uncontrollable life stressors (Linden, 2005), and are known to be effective as a treatment for depression. The bottom line is that 'The bright side of being blue' makes sense for people with depressive mood, but is losing its 'brightness' as the depression worsens and neuro-endocrine changes become major drivers of patients' subdued behaviour.

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