

Depression

"I feel so low... I can't cope."

Depression is one of the most common psychological problems. About one in ten people in the UK suffers from depression at any given time, and most people experience it at some time in their life. Many will not recognise it as such, saying instead that they feel "sad", "low" or "down in the dumps", and indeed it is often a short-term episode which can be clearly linked to personal difficulties, such as a bereavement or other loss. However, for a lot of people it can last much longer, perhaps years, and may not be so clearly related to life events.

What is depression?

There is no single, simple diagnosis for depression, but it is likely to include:

- low mood, with feelings of sadness, despair, emptiness or tearfulness, and/or
- an inability to take pleasure, or as much pleasure, in activities which would normally be engaging and enjoyable.

Other common symptoms include:

- unplanned or unwelcome changes in weight,
- changes in sleep patterns,
- loss of interest in sex,
- loss of normal interest in other people and increasing social isolation,
- persistent tiredness and lack of energy,
- irritability, restlessness or agitation,
- feelings of worthlessness, inadequacy or excessive guilt,
- difficulty concentrating or making decisions,
- lack of self-confidence and/or feelings of hopelessness, and
- thoughts about death and, in particular, suicide.

Anyone who has five or more of the symptoms from the two lists above, or who has started to think about death and suicide may be severely depressed and should visit their GP as soon as possible.

At its worst, depression is a crippling and even life-threatening state. Even when it is not, it is a miserable, debilitating condition that often attracts little sympathy from family, friends and colleagues.

And the good news?

The silver lining in the heavy black cloud of depression is often hard to find. Nevertheless, many psychological models see depression as a normal healthy state – at least so long as it does not set into a chronic condition and do serious damage to the way a person functions. At the very least, depression is a sign that something is out of step and needs to change. Often depression is associated with loss, and life involves many "necessary" losses if an individual is to grow and experience it fully. Depression can be a perfectly normal response to the inevitable losses of life. It may be a passage from one stage to another; sometimes it is a "wake-up call" to let old ideas and viewpoints go so that life can be experienced and enjoyed in new ways.

The other good news is that depression often resolves in the face of patience, compassion and common sense. Even if it does become severe or persistent, it is usually very treatable.

What do all the different words mean?

Psychologists classify depression by the severity of the symptoms and the length of time they persist. The term depressive episode is used for a state lasting for two weeks or more (except in the immediate aftermath of a bereavement.) Where depression recurs, a depressive disorder may be diagnosed. Persistent low-level depression may be called dysthymia or a dysthymic disorder. Where dysthymia worsens into depression, the phrase double depression may be used.

Depression may be described as endogenous if it is thought to arise from some chemical imbalance in the brain unrelated to life events, or exogenous if it is triggered by external events. If it is clearly related to an obvious difficulty such as divorce or redundancy it may be called reactive. If the precipitating event appears to be too small to account for the severity of the symptoms, but if there are clear links with earlier life incidents, perhaps from childhood, it may be styled abreactive.

The older word, melancholic, is still used to describe a type of depression with certain clinical features (most particularly an inability to take pleasure even in favourite activities or when something good happens). An inability to experience pleasure is also known as anhedonia.

The symptoms of depression can be caused by drug or alcohol abuse or by taking prescribed medication. They may arise as a result of a physical medical condition, in which case the depression is termed secondary. Any depressive episode without a very obvious non-physical cause should be met by a routine physical examination, and possibly hospital tests.

Postnatal depression is one of a number of postpartum mood disorders which can begin within four weeks of giving birth. More serious than the "baby blues" which affects 70% of women in the 10 days after childbirth, such mood disorders can include severe anxiety, delusions, or a marked lack of interest in the new baby. They should be taken very seriously and treated quickly, as they can result in long-term damage to both mother and child. Depression is also one of a number of symptoms common in pre-menstrual syndrome (PMS, also referred to popularly as PMT.)

The term manic depression has now largely been superseded by the term bipolar disorder (sometimes bipolar affective disorder). This diagnosis is likely to be applied when a depressed individual has also experienced at least one period of markedly elevated mood – a manic "high" – that is not due to drugs. Manic episodes are marked by inflated self esteem, decreased need for sleep, unusual talkativeness, racing thoughts, difficulty following a train of thought, and often wildly enthusiastic involvement in a variety of activities, many of which can lead to trouble. Although many with the condition find their manic periods life-enhancing and creative, sometimes the consequences can be disastrous. The term hypomanic may be used when a person's functioning is not too seriously impaired by this high phase. A cyclothymic disorder may be diagnosed where there are long-term symptoms of mild to moderate severity. The word unipolar is sometimes employed for depression where mania is not present.

Anxiety sometimes accompanies depression, when the term atypical may be used. Symptoms may include panic attacks, phobias and obsessive-compulsive behaviour. Occasionally depression can be accompanied by psychotic symptoms, such as delusions, hallucinations or hearing unhelpful voices.

Depression or other mood disorders can have a seasonal pattern, and seasonal affective disorder (SAD) is thought to give significant problems to perhaps 5-10% of the population between the months of October and April.

Depression can be confused with other psychological states, such as sadness, grieving and confusion, and busy GPs sometimes use it as a catch-all diagnosis to cover the wide range of unhappiness they encounter in their surgeries.

What causes depression?

Depression is associated with a low level of certain chemicals, called neurotransmitters, in the brain.

The brain is formed of billions of long, thin nerve cells rolled into a ball. Nerve impulses themselves are electrical, but the current cannot jump from cell to cell. At nerve endings tiny amounts of neurotransmitters are released by the electrical impulse. These then make their way across the microscopic gap (known as a synapse) to the next cell, where the incoming chemical triggers a new electrical impulse. The neurotransmitters are then broken down and reabsorbed so that the synapse is clear and ready for the next incoming impulse.

Depression can occur without any obvious external trigger just because, for some internal reason, the brain is not sustaining a sufficient level of certain neurotransmitters.

There is evidence that a tendency to become depressed may be hereditary. Having a depressed parent (or parents) raises the chance of an individual becoming depressed themselves. There could be all sorts of reasons for this related to early life experiences and parenting, but even where children are adopted by non-depressed parents, they are still more at risk of depression.

Depression can certainly be triggered by drugs and medical conditions. Those being treated for heart disease, high blood pressure, Parkinson's disease, or with steroids, are more at risk. Depression is also linked to a wide range of recreational or hallucinogenic drugs, including alcohol, as well as being one of the withdrawal symptoms from another long list of such substances.

The medical conditions that can cause mood symptoms include Parkinson's disease, Huntington's disease, strokes, vitamin deficiencies, hormonal disturbances, viral conditions, ME/CFS, HIV and cancers. Of course, many terminal, painful and degenerative conditions also have seriously depressive effects.

The effects of hormonal changes or imbalances on mood are clearly felt in postnatal depression (and other post-partum mood disorders), pre-menstrual syndrome, and seasonal affective disorder. Depression is also linked with a low level of thyroid activity.

For most cases of depression, however, there is likely to be an external trigger in terms of a life event. This is likely to be some sort of loss:

- loss of closeness
- loss of love
- loss of self
- loss of face
- loss of freedom
- loss of safety
- loss of trust
- loss of support
- loss of hope
- loss of faith
- loss of innocence
- loss of certainty

Typically such losses can be brought about by bereavement, divorce, accidents, crime, illness, insolvency, redundancy, retirement, marriage, parenting, isolation, failure and stress. In many cases, an apparently moderate loss in the present (such as losing a pet or failing an exam) may resonate with much bigger issues from the past which have been buried away and ignored.

How can depression be treated?

It cannot be emphasised too strongly that depression is a life-threatening condition. Where severe depression takes a long-term hold, 15 per cent of sufferers go on to commit suicide. Even single episodes, if they are black enough, carry a serious risk of suicide.

Sometimes, of course, suicide attempts are just "cries for help". Every year, many people die crying for help. Attempting suicide is dangerous.

Anyone suffering from depression should see a doctor, and if the symptoms are severe or include suicidal thoughts, there should be no delay. The two main treatments for depression are antidepressant drugs and talking cures like psychotherapy and counselling. If the symptoms are severe or overwhelming then the patient may not be able to engage with talking cures, and will need to be stabilised and brought back to a place from where they can deal with the world again. It may be necessary to provide a safe and containing environment while they do so.

Antidepressant medication

Antidepressant drugs are likely to be the first treatment of choice for many doctors, and certainly where the symptoms are severe. The majority work by raising the level of neurotransmitters in the brain (see above). They do this by reducing the rate at which neurotransmitters are taken out of circulation after they have done their job bridging the electrical gaps between nerve cells. They may also, indirectly, increase neurotransmitter production.

Although there are many different kinds of antidepressants, they are all about equally effective. However, they do not all work equally well for any given individual. There is about a two-thirds chance that any given antidepressant will be effective in any given case. If it doesn't work, then there are plenty more to try. There are several different groups of antidepressant, and many different types within each group.

Unfortunately antidepressants take time to start working – usually at least a couple of weeks to get any useful effect. It takes at least six weeks to be reasonably sure that a particular antidepressant is *not* going to work. There may even need to be a gap between taking an unsuccessful antidepressant and trying a new one. If antidepressants do work, they are likely to build up to full effectiveness over a few weeks.

Antidepressants can have side effects, and the list for the whole family of them is so long and so daunting that there is little point giving it here. Look inside the pack. A doctor should also explain what to look for and when to report any difficulties. Most side effects are relatively minor and are likely to wear off in the period that the antidepressants take to start working.

Many patients do not persist with antidepressants long enough to get any real benefit. It has also been true that in the past many doctors have not prescribed them at a level sufficient to work properly. It is important that antidepressants are taken at the full dosage prescribed, since a lower dose may have no effect at all. Antidepressants should normally be taken for at least four to six months after they have reduced the symptoms, and there may be a case for long-term use. No-one should come off antidepressants quickly, other than for clear medical reasons, and they are usually “tapered off” by reducing the dose gradually. A sudden stop may provoke further depressive symptoms, even where the antidepressant doesn’t seem to have worked. If a successful antidepressant is stopped too quickly, and a depressive response is triggered, there is no guarantee that it will work so well again at the old level.

Other non-talking cures

The most famous – or perhaps infamous – non-talking cure for depression is electroconvulsive therapy (ECT, or electroplexy). Despite some horrific literary and biographical accounts, it has often worked very well in patients where quick results are desperately needed (the catatonic or severely suicidal) or where drugs and psychotherapy have failed. The modern treatment is much less frightening and traumatic than in the past, and it still has a cautious place in the medical armoury.

Modern therapies such as transcranial magnetic stimulation (TMS), vagal nerve stimulation (VNS) and cranial electrotherapy stimulation (CES) have all offered some hope for treating depression but are not yet convincingly established in the UK.

Complementary medicine offers hope to many depressed patients, but it should not be the first port of call for anyone with severe symptoms and should not distract from obtaining a proper medical assessment. Herbal medicine (particularly involving St. John’s wort (*Hypericum*) and Ginseng) has been shown to help, but herbs are drugs, and all drugs need to be administered in the correct dosage and with an eye to side-effects and reactions with other medicines. In particular, St. John’s wort has potentially dangerous interactions with many other drugs, including some antidepressants. At the very least, check with your GP first.

Other alternative therapies for which claims have been made include homeopathy, aromatherapy, Bach flower remedies and Rolfing. There are also a number of other therapeutic activities which may impact on the feelings that often underlie depression. For example, proper diet, dance, Tai-Chi, yoga, massage, a spiritual path, meditation, friendships, assertiveness training, anger management, art therapy and Alexander technique all tend to make people feel better, and may help to lift them out of a depressive

mood. They are best thought of as part of the convalescent phase of a depressive illness, and as part of the long-term management of a temperament that is liable to depression.

Exercise is a fairly reliable way of fighting low-level depression. It undoubtedly helps to take regular aerobic exercise (slightly short of breath for 20-30 minutes, 3-5 times a week). Exercise produces endorphins (natural opium-related substances) in the body and mops up the chemical products of stress. It also tends to make people feel better about themselves, and often gives them a welcome change of scene. Fit people tend to be less depressed. But be warned: anyone who deals with a bereavement by running fifty miles a week and then pulls a muscle is in for a difficult time. And there are no prizes for avoiding depression by dying of a heart attack.

Psychotherapy and counselling

Human contact, particularly when there are feelings of loss and isolation, can be very helpful in alleviating depression. But often a depressed person finds normal relationships difficult. They can feel that they have exhausted their friends and that no-one is prepared to listen to them anymore. Moreover, families and loved ones can sometimes seem part of the problem.

Psychotherapy and counselling are only of limited use when depression is very severe. Antidepressants and even hospitalisation may be needed just to bring a patient back to a level when they can start to relate to the world again. Above all else, the talking cures do their work through relationship. Relating therapeutically can sometimes seem very new to people, and a deeply depressed state is not a great place to start dealing with anything new.

Psychotherapy and counselling come into their own where the depression is only mild to moderate, or when more severe symptoms are responding to antidepressant medication. Medication may lift a mood considerably, but it is unlikely to resolve any underlying problems. The talking cures help clients examine their world and start to put their life on a firmer and more satisfactory footing.

Psychotherapy and counselling can help in a number of ways. Even when medication is the primary means of treatment, antidepressants take a while to kick in, and there can be delays while physicians find the right medicine and the right dose. At this stage, the main role of the counsellor is one of support. It can sometimes be an enormous relief for a client just to feel seen and heard. For one reason or another, some people have never felt able to spend an hour, in their whole lives, just talking about themselves and how they experience the world. There are cases (though admittedly very rare) of apparently depressed clients feeling so overjoyed by the experience that they have phoned in before the second session saying that they felt completely better and did not need to come again!

A good therapist will sit with you and share your experience of life. They will show that they have understood, and may even help you find your own words to describe where you are. As trust develops and the relationship develops, they may be able to help you find ways of visualising or describing your situation that helps you see the way forward more clearly.

Therapists who work cognitively or practice Cognitive-Behavioural Therapy (CBT) can often be a big help at this stage. The way we feel about things is often largely determined by how we think about them. We make assumptions about our experiences that influence how

we react and feel. These assumptions are not always true, but may have been learned or arrived at so long ago that they are now our second nature. A good cognitive therapist will help to unearth those assumptions and see if they are really as true as we have always believed. If we can think about things differently, we will start to feel differently too. Life can start to seem a lot less depressing.

Long-held beliefs and feelings are usually determined by childhood experiences. Working psychodynamically can often help us get right to the root of our experiences. This can put us in touch with a lot of feelings that are generally unwelcome in the normal social, adult world – like rage, anger, shame, jealousy, envy, fear and greed. Often these are bottled up so that they only occasionally show themselves directly. But they can have a powerful unconscious effect, and when they do “blow”, they can seem unbearable. In a safe environment these can be unpacked and examined. Doing so can reduce them from titanic, overwhelming forces to much more manageable proportions. The process can be difficult and takes some courage, so it is not a good starting place in treating depression, but it can be an important part of a successful outcome.

Therapy is mainly about inner changes: changes in the way individuals feel and think about their experience. Often that is all clients need, but depressed people may need to make changes in the outside world – the circumstances of their life that invite depression in. The client may decide that a relationship needs to be changed, a job left, or a new course followed. Sometimes inner changes seem to clear the way miraculously for new developments in the outer world, but at other times life, and the people we are involved with, put up a lot of resistance. Good therapy will give a client new insight and new resources to make change possible.

As noted above, depression is usually about loss, and loss involves a transition from one life state to another. Sometimes we are not at all keen to allow those changes. Depression can be a sign of that reluctance. We want to hang onto the old ways, and something needs to happen to let us go forward. Looking at depression as a natural, even healthy, process can be a way of standing back from our immediate experience to see the bigger picture. A therapist from a broad humanistic or integrative background can be very effective in giving us the perspective to see what is trying to emerge, and helping us find the resources to allow it to happen. Therapists with a Jungian or transpersonal outlook have a special interest in the stages of the life – the journey of the soul to full expression – and are trained to act as “midwives” to new parts of the self as they struggle to appear. Some may have a spiritual framework to help them make sense of these mysterious processes, but they will not force any specific model onto your experience. Instead they will help you make sense of things in your own terms.

How can I help myself?

If you have family, friends and acquaintances around when you become depressed you may quite quickly become faced by a well-meaning list of things you *should* and *ought to* do. You should feel grateful for this or that; you ought to remember so-and-so who has things much worse; you ought to pull yourself together and move on; you should take this or that supplement; you should try this meditation; you **MUST** take relaxing baths with candles, etc, etc.

A diet of shoulds, oughts and musts is not a very healthy one for someone suffering from depression. It may even be part of the problem.

However, there is one "should" you really *must* heed. If your symptoms are severe (see the lists above), or are getting worse, or if you are having ideas about death and suicide, you should seek professional help without delay. This is an absolute bottom line.

The trouble with most of the oughts and musts is that they can seem very overwhelming and carry a risk of failure. This meditation hasn't helped; I must have done it wrong. This essential oil has made no difference; nothing will ever help. Depression often carries a strong feeling of failure with it. You don't need to add to your burden. You can also end up doing things just to please people. What does this do to your own – perhaps very bruised – sense of self-worth?

Depressed people often talk of "duvet days" (or something similar): days when all they can do is get under the bedclothes and stay there. Depression can be a time of vulnerability, nakedness, aching inadequacy. Wounded animals often retire into caves or crawl under rocks. Perhaps you need to find a rock.

Very primitive animals, like amoebae, relate to the world very simply. If they sense something nourishing in their environment they inch very slowly towards it. If they sense something threatening, they move away. You may find that your primitive self can guide you to what you need.

But can you trust it? Some impulses in depression seem unhelpful and self-destructive. That's why it's helpful to find a dispassionate person to help you check out your environment in case your normal processes are not working properly.

There are a few things which are likely to help if you can do them. Eating properly helps. Avoiding alcohol helps. Sleeping well helps. Taking moderate exercise helps. Getting outdoors into the light, and having some contact with the natural world helps. Being listened to and heard helps. Avoiding anything (or anyone) that palpably lowers your mood helps. Avoiding stress helps. Doing things you enjoy helps. If you are not able to manage enough of these on your own to start making a difference, you probably need some help from outside.

I do not know how many of the following ideas have been tested clinically, but I include them as suggestions taken from recent psychological research.

(1) Keep warm

A cool night-time vigil or a chilly walk may suit your mood, but there is evidence that we associate the cold with loneliness and rejection. Wrap up warm or seek out the sun and, if you cannot avoid cold conditions, make sure you get warm properly afterwards.

(2) Keep clean

It is important to maintain basic human functioning when we feel down. Poor personal hygiene may trigger feelings of shame and guilt, which can be part of the depressive cocktail.

(3) Don't scare yourself unnecessarily

"Recreational fear" can be induced by dangerous sports such as rock-climbing or bungee-jumping, and by stimuli like roller coasters and horror films. A hit of adrenaline may feel good at the time but it may be a short-term fix. Fear underpins anxiety and phobias and there is evidence that it can make new or difficult tasks seem even more daunting than they are.

(4) Don't get too tired

There seems little doubt that good physical fitness and moderate levels of exercise can counter depression, but pushing yourself to exhaustion is not a good idea. As with fear, tiredness can make difficult tasks seem harder. When you exercise or work hard, make sure you recover properly and avoid running on empty.

(5) Seek out happy people

Mimicry is an innate quality in humans and people who interact well often copy each other in all sorts of ways, often small, and often below the level of consciousness. Being with people who generally enjoy the world is likely to rub off.

(6) Get things done by thinking concretely

Putting things off damages self-esteem and can foster feelings of guilt and powerlessness. Evidence suggests that focusing on immediate details – the how, when and where of a task – is more likely to lead to action than abstract thinking. People who concentrate on the big picture – why they are doing something and the long-term results they want to achieve – are more likely to procrastinate.

(7) Don't be afraid of nostalgia

People who are depressed or who are sad from a loss often feel the right thing to do is to put things behind them and move on. We seem to have almost in-built contempt for "wallowing" and sentimentality. Studies suggest, however, that nostalgia may open the door to certain restorative experiences, and that the use of nostalgic memories as a coping strategy is associated with resilient personalities.

(8) Cultivate strategic gratitude

It has long been recognised that gratitude is a helpful emotional state but, "think of all the people worse off than yourself" just doesn't seem enough when the chips are down. What seems to work better, however, is to look at some of the good things in your own life and reflect on how fortunate you were that they happened. Spend a few minutes a day "undoing" the good things that have happened to you and you will start to appreciate them more.

How can I help someone suffering from depression?

Being with a depressed person can be upsetting and frustrating. Perhaps you can see what they need to do, but for some reason they either can't or won't do it. They're in a dark hole and you can't reach them. You need them back.

The most important way you can help is to help someone seek professional help. If their symptoms are severe (see the lists above), or are getting worse, or if they are having ideas about death and suicide, seeking medical help is an absolute priority. Ideally the depressed person themselves should make the first move to get help. If they do, they may need emotional support and practical help to carry it through. If things are very bad, someone else may need to make the first move.

For someone mildly-to-moderately depressed, or for whom the medical wheels have already been set in motion, the most important thing you can do is to be there for them. Being present is about listening and trying to understand what is going on for them. It is about showing that you have understood without judging. It is about showing that you (who hopefully are in a much better state and have other resources to draw upon) can bear to experience what they are facing, and can sit in it with them without flinching or giving in to the temptation to try and "fix" things. If you start using sentences that start, "you should...", "you ought to...", "you must...", you are trying to fix things. Even, "have you

tried...”, or “when that happened to my Uncle Archie he did so-and-so...”, are likely to be attempts at fixing. Depressed people are often already overwhelmed by “shoulds” and “oughts”. Just be with them. Just listen and show that you have heard.

It may be hard to listen to thoughts about suicide. There is a prevailing idea that talking about suicide will make it more concrete and more likely to happen. In general this is not the case. A lot of people who commit suicide never share the idea with anyone. It is one of those things that is hard to hear but much better out in the open. You should show that you are prepared to listen and can even ask questions about when or how they might do it. You can also say what it would mean to you if they were to die in that way – but don't lay on a depressed person the responsibility for keeping you happy.

Much of this is not easy. Being with a depressed person can be upsetting and exhausting. You cannot show care for them if you do not take care of yourself. You need time out, nourishment, pleasure, fun. You may need to give of yourself completely while you are with them, but don't give more than you can. It is much better to spend an hour with someone, listening, empathising and holding (whether literally or not), than six hours which starts off with the best of intentions but ends up with you getting exasperated, ratty and distant. This may just confirm to them that they are “bad”.

Depressed people need good boundaries. They need some dependability in their environment. You can be part of their “rock”. If you think you can only manage an hour with them, say that you will be staying an hour – and do it. If you intend to come back tomorrow, say so – and do it. If it's OK for them to wake you in the middle of the night, tell them, but be prepared to deliver.

In fact don't promise anything you can't deliver. Being with a depressed person often puts us in touch with dark thoughts and difficult feelings within ourselves. Look out for occasions when you may be tempted to say things that are more about reassuring yourself that you are a good person, or that you are “all right”, than they are about really helping the other.

Getting through depression is a marathon, not a sprint – for everyone closely involved. You will make mistakes. This is OK. It is human. Just do what you can and keep your heart in the right place.