DEPRESSION

by

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Many people experience depression. It is as if they were caught up in a sea mist which suddenly envelopes them and cuts them off completely from those around them. There does not seem to be any way out as all the familiar landmarks are shrouded in the mist. They feel like a sailor would, caught in a mist without a compass or any radar equipment. Despair takes hold; one feels isolated and the situation seems to be hopeless. The emotions seem to be deadened: concentration becomes more difficult and decisions are avoided. Some wonder if they are going mad. One of the most common reactions is for people to blame themselves. The sense of hopelessness is very persistent and suicide is frequently seen as a solution to the unbearable psychological pain. The constant repetition of negative thoughts of failure and impending doom continually reverberate in the brain. The natural escape of sleep is denied as there is a continual waking restlessness, agitation and nightmare.

One of the dangers is for relatives and friends to underestimate the seriousness of a depressive state which can easily happen as the term 'depression' is used very freely. People talk about being depressed because of losing a game, a bet, or when the weather is bad, when they are really just fed up and sad. Depression is not about being fed up or feeling sad. The depression we are considering is a state of prolonged hopelessness and despair and sometimes ends in sucide.

People down the ages have sought help from a variety of sources depending on their cultural setting. In recent years many more people, especially in Western societies have turned to medicine and psychiatry. In consequence depression has been approached according to the medical model which has attempted to define depression in terms of a clinical picture. Therefore it has been regarded as an illness and a matter for psychiatric treatment. Out of this has emerged a classification of two types of depression, endogenous and reactive. The first, endogenous, is regarded as the most severe and seems to develop from within the person, unrelated to external causes. Dr. Jack Dominian points out that, 'it is triggered off by factors which belong to the basic personality and

set in motion by biological changes in the organism, obeying their own rules which are not easily understood. Patients often ask in a puzzled way the reason for their illness when they cannot recognise any stressful event responsible for it.' (1) Some studies would make a strong case for genetic inheritance as a major contributory cause.

The second, reactive depression, is described as a reaction to loss, some deep emotional hurt, feelings of personal rejection, repressed anger and frustration. Loss of a relative or partner, loss of job, self esteem.

In the following table Dr. Dominian gives a very clear presentation of the clinical differences.

The great debate among different psychological approaches and psychiatrists themselves, is about whether depression is caused through unresolved psychological problems and stress or biochemical disorders or a mixture of both.

Although these different views will have some fundamental effects on how depressed people are helped, it is beneficial to continually research and debate these issues, as our knowledge is still so very limited. However there should always be the one proviso and that is that the depressed person must not be allowed to become a pawn in the experimental theories. There are certainly many depressed people who feel so emotionally crippled that they are literally prepared to try anything. However the truly caring helper needs to take cognisance of all the various resources that are available and advocate what seems most suitable for a partricular person.

It is very understandable that those who are in a depressed state want the experience to go away, to be cured, healed, become happy; and the helpers, doctors, psychiatrists, psychologists and therapists want to heal or at least relieve their sufferings.

'Depression, in this century, has been called an illness and treated with pills and E.C.T. Some people are greatly helped by this treatment. Their depression vanishes, never to return., However, for some people, pills and E.C.T. bring only temporary relief or no change at all. For those people something more is needed, and this is not suprising, since being depressed is something more than being ill.' (2)

Many who feel depressed, especially children and young people, will mask their depressive reactions. Sometimes his is characterized by unusual behaviour, or by denial as in the smiling depressive, The big danger here is that the unusual symptoms are often misleading and so go unnoticed. Rene Diekstra reminds us that 'In order to comprehend this well, one has to realise that, contrary to the current view in medical and psychological science, depression is in fact not so much a clearly defined syndrome or clinical picture, but rather an effect, or state of mind resulting from psychic collapse and hopelessness or impotence.' (3)

Table I
Characteristics of Depression

Psychological	Endogenous	Reactive
Mood	A shift towards depression is marked, continuous and usually worse in the morning. in the evening and	The mood is less severely depressed fluctuates and gets worse, if at all, in the evening and when alone.
Psychomotor	Is marked and expresses itself by a general slowing up in thinking and activity.	Not marked, if at all.
Agitation Anxiety Irritation	Agitation is usually present.	Anxiety and irritability are the principal characteristics. Fears are commonly present.
Feelings of inferiority uselessness and hopelessness	Markedly present but disappear with the lifting of the depression.	Not so pronounced but often other variations in the personality present.
Delusions of self-reproach and guilt.	May be marked.	Usually not present.
Hallucinations.	May be present.	Absent.
Physical Insomnia	Marked, characterized by early morning waking.	Marked, characterized by difficulty in going off to sleep and further interruptions.
Appetite and weight	Severely affected	Usually little change
Libido	Can be lost completely or partially.	Usually little change.
Energy	Markedly reduced	Variably reduced.
Bodily pain	Present - clears up with lifting of depression.	Present - may clear up or persist.

Whilst it is humane and essential to try to reduce the emotional pains caused by depression, we have to acknowledge that, for the most part, with drug therapy and a lot of psychological help, we are dealing with symptoms rather than causes. In recent years there has been a much greater interaction between the psychological and sociological approach. It is recognised that each generation has to learn how to cope with their particular environmental emotional needs and conflicts. The common denominator found in depressive and suicidal states is a sense of isolation, a feeling of being cut off, and for many, deeply repressed feelings of anger. During the last 200 years the rate of change in our western society has been faster and greater than at any time in human history. The faith in rationalism and science prepare the way for the industrial and capitalistic way of life. Many of our forebears were convinced that this kind of world would lead to a Utopia, but it would seem that they underestimated their emotional and spiritual needs and the dangers of a competitive society. We can only ignore our emotions at great cost to our integrity as people. Whilst all of us are prone to our personal neurotic reactions, there does seem to be a great increase in inner loneliness or what some psychotherapists describe as the schizoid reaction. It would seem we need always to be tuned into our current cultural climate and how this affects our emotional and rational reactions to the drama of daily life. As we struggle to discover some of the underlying contributory causes of depression we need to acknowledge the depersonalizing effects on humanmity of the gross misuse of our science and technology. Albert Camus begins his essay The Myth of Sisyphus, 'There is but one serious philosophic problem and that is suicide.' (4) This comment is particularly appropriate to the 1980's because during the last seventy years, in the west, we have been exposed to ever-increasing diametrically opposed phenomena. On the one hand there is great success in prolonging life through medical science and on the other, the developing of weapons capable of total annihilation. Alvarez writes, 'In every age man faces a pervasive theme, which defies his engagement and yet must be engaged. In Freud's day it was sexuality and moralism. Now it is unlimited technological violence and death.' (5) Today we are subjected to a great barrage of aggressive behaviour on television news bulletins where the deaths of literally thousands of men, women and children are commonplace. Yet death is a taboo subject and not freely discussed. It is ironic in this age of extensive technical communication, the age of 'public relations' that so many thousands of people, especially young ones, feel they can only communicate their inner emotional distress through taking an overdose.

> 'It is not always appreciated that many who behave in his way are men and women of considerable integrity and intellectual abilities, who feel trapped in a meaningless and dehumanized world. It would

be short-sighted to underestimate their emotional vulnerability, as already for many the aggession is turned onto themselves in suicide, as they feel life is unbearable.' (6)

'Thirteen thousand suicide attempts by young people, and recently also by children, in one year in the German Federal Republic represent a terrifying question to the adult world, which has no cause to be surprised when many young people adopt the slogan "happiness now" and find themselves driven into a tragic conflict with reality. Here we come up against the same sociological symptoms to which the alternatives also react.' Erwin Ringel, the Viennese expert on psychosomatics and one of the best known suicide researchers illustrates this with a poem by a school leaver.

I wanted milk
and got the bottle
I wanted parents
and got a toy,
I wanted to talk
and got a book
I wanted to learn
and got reports,
I wanted to think
and got knowledge
I wanted a survey
and got a glance,
I wanted to be free
and got discipline
I wanted love
and got morality,
I wanted a calling
and got a job,
I wanted happiness
and got money,
I wanted freedom
and got a car,
I wanted a meaning
and got a career,
I wanted hope
and got fear,
I wanted to change
and got sympathy
I wanted to live . . . .

These kinds of reactions could be better described as causing a state of dispiritment, rather than clinical depression, which clearly can lead to despair and suicide At the same time, it is very understandable for these despairing reactions to be diagnosed or assessed as symptoms of depression. Yet many of the most experienced psychiatrists involved in care and research into parasuicide have found that the majority of those involved are without any known psychiatric disorder. Yet it is estimated that every year in England and Wales, over 100,000 people are involved in this kind of suicidal behaviour, especially among those under 25 years of age, with a higher proportion of females. A large number of these do not cooperate, or reject any ongoing psychiatric help. It would seem that most of these people are trying to communicate how anxious, distressed and angry and frustrated they are feeling.

We may have some clues to a better understanding and care of those depressed if we are able to be more flexible in our assessments, Carl Rogers writes, 'I believe that individuals are probably more aware of their inner loneliness than has ever been true before in history. I see this as a surfacing of loneliness - just as we are all probably more aware of

inter-personal relationships than ever before.' (8) He also points out that, in the West, the majority of us have time to experience our loneliness as we seek to find meaning in our lives. We then, of all people, must be aware of the deeper underlying changes by the human seeking after self-realization. How do we cope with this need to find our personal identity? Today people are encouraged to talk more openly about their feelings than in the past. Modern education tends to include more student participation. In selection procedures for many business, professional and voluntary work, good performance in a group is an essential requirement. Plus, televison and radio give prominence to personal experience as it is so essential to uncover real feelings. Could it be that we are trying to emerge out of our schizoid and dehumanizing experience of the recent past? There are a number of positive signs that this is happening, e.g. greater participation of large numbers of people in society in voluntary and caring support groups, the creation of many self-help groups and the greater increase in the so-called 'talkng therapies.'

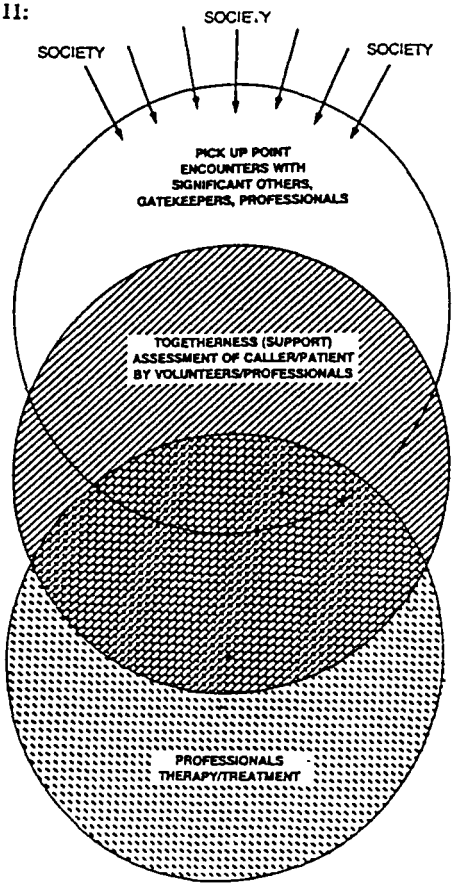
All these changes result in many more people seeking help with their emotional life than in the past. Also our expecttions for a better quality of life are increased. This is well demonstrated in the Womens' Movements and those concerned with the preservation of the natural environment. The growth of the Samaritans with 187 branches and over 21,000 volunteers is a good example of how the community can be motivated to express care and responsibility for the depressed and suicidal. One of the major causes of a lot of depression is that people find it so hard to care for themselves, to love and forgive themselves. This is not surprising because truly caring for yourself involves coping with the darker side, the destructive, negative and frightening aspects of ones' self. If this were not bad enough, we also have to accept the necessity to be dependent upon the help of others, even those we dislike. This awakening of our needs for closer relationships may be cause for a great deal more anger and frustration for many people with serious relationship problems. The aggression may be expressed in anti-social behaviour or turned upon oneself resulting in a depression. However, if we can give ourselves permission to care for ourselves, it will help us to become more mature, couragous and responsible for our actions.

As we are all dependent, to a great extent, upon the values and political attitudes of society as a whole, we have to help the community life become less desperate. For some, this will mean active political involvement and for all of us, a responsibility to sharpen our social consciousness. We need to work hard on overcoming our inner desperation because this is bound to result in an increase of depression and dispiritment. There is the danger that, despite all our expertise, we get over exposed. We have to grapple with knowing so much but we do not have the space to feel. We are so near each other, yet so far apart.

The constant movement and changes in our modern society caused by divorce, family break-up, unemployment and the impersonal effects of a lot of our working conditions means many people are more or less forced to go it alone. Therefore the establishing of a rapport and acceptance between persons especially when depressed or in a crisis is so important. Because this creates a kind of 'togetherness.' It is the experience of the Samaritans that many of their callers use them as a kind of substitute family.

'In figure II, you will see from the use of three circles that there are three significant areas which may be identified in providing help. You will notice the three circles interlock and this highlights the modern trend towards an inter-disciplinary approach.' (9)

Figure 11:



The Pick-up Point

If we recognise coping with depression and suicide is everybody's business, then how those concerned get together will have a tremendous effect on the depressed.

In circle 1 are the sensitive and caring people of the community. This would include friends, significant others, gatekeepers, good neighbours and the Samaritans, as well as professionals, especially GPs and social workers. You will see those on the edge of this circle operate in the main on the frontier points of society and as we move into the circle they open the way for the creation of togetherness and support and professional help. This then is the pick-up point, those who are available should be likened to those who operate radar screens used so extensively in air and sea communications, for everything depends upon how well problems, new situations and changes are identified. We may have some excellent resources, very committed volunteers, deeply caring and expert professionals, but none of these will be used unless there is a successful pick-up or a meaningful response to a request for help. This applies to all our encounters and our difficulties are far more complex than those experienced in any radar operation, as we are trying to relate to people and not objects.

In very simple terms, we can expect to encounter at the pick-up point:

1 Those who want help and ask for it; sometimes they may be rather vague about what they need or want to receive, yet it is recognized beyond question that the most positive relationship and help can be given when the person wants it.

2 Those who find it hard to co-operate, though they want and need help. This would include the very depressed, who do not think they are entitled to help: others who find it hard to trust people, generally the result of bad experiences from early childhood, and those who get out of touch with reality and are likely to be labelled mentally ill or psychotic. Some will respond well to a sensitive encounter whilst others may consider co-operation is ridiculous or too dangerous.

3 Those who are very demanding and frequently make extensive use of voluntary and professional services. They often have a special capacity to' wind up' the helpers with dramatic stories and sometimes threats of suicide.

4 Those who seem to be very indadequate, either presenting very dependent or aggressive reactions, often labelled chronic. An early recognition is essential in order both to help the depressed person and to prevent the wasting of helping resources.

5 Some of the most depressed people will be those who are referred to helpers by a third party or, as it were, dragged in for help. These kinds of encounters demonstrate again the need for the closest co-operation and

mutual trust between the general public and the helpers, voluntary or professional. There are two fundamental distinctions to be borne in mind when seeking help. Voluntary bodies who insist on having permission and respect confidence before taking any action, do not have any statutory authority or responsibility: this is especially so of the Samaritans. The social services, GPs and psychiatrists have defined obligations to people care, treatment and management. Most helpers, not least professionals, are uneasy about responding to third party intervention. In some cases it will be necessary to section patients, detain them under the Mental Health Act, both for the care and protetion of the patient and of the community. The modern approach in psychiatry is to section patients for the shortest possible period. This is in keeping with a more humane attitude. Unfortunately, at times it can heighten the suicide risk. It is the experience of most Samaritan branches that, handled with sensitivity and understanding, the majority of people referred are able to accept help.

Those who provide counselling or psychotherapy, whether on National Health or privately, for individual or group work, insists that the person asks for such help. They would be required to enter into a contract based on mutual cooperation. The caller/patient must be free to stop the sessions or walk out of them. They must be free to make their own choices. This sometimes confuses relatives, friends and other helpers of those in therapy, because it may well involve the risk of suicide. However, these therapeutic units will have medical and psychiatric back up. DHSS referrals will have had a psychiatric assessment. It is not unusual for relatives and sometimes neighbours, to more or less force someone to see their doctor. Sometimes medical or psychiatric treatment is needed and can be arranged. What is unfair is to expect a busy GP to take over all kinds of social problems or be expected to treat and care for a patient who does not want help. The doctors and social workers tend to use compulsory powers of the Mental Health Act with great discretion, and quite often only as a last resort.

If you, as a relative or caring person, are concerned about someone who is very depressed, mentally ill, and a possible danger to themselves and others, and it is clear to you that they will refuse help, there is no point in involving Samaritans or voluntary bodies. They are likely to need a doctor and social worker with authority to take the appropriate action. Although they may certainly benefit from some follow-up support.

Many people who are not involved in helping roles either as volunteers or professionals, will have had some experience of people in the five groups mentioned. In the course of our daily lives we often give support to many different people and for those of us with the care of children and the elderly, the making of assessments as to their needs regarding medical help and crisis situations are quite

common - therefore the average responsible caring man or women can be invaluable for the depressed at the pick-up point. Let us look at some examples.

The caring person who listens to the neighbour when they feel the need to talk about their worries. You may know about some recent illness in their family, a loss, trouble with police or the neighbour may just look down or upset. You begin to recognize their needs. It may be wiser to follow up a conversation with a visit or suggest he or she comes for a chat.

The milkman, shop assistant, hair-dresser, policeman, lawyer, indeed any of those serving the community, the 'gate-keepers' as the Americans call them. Many of you will have regular encounters with your customers and clients, and although you may not have talked with many for any long period, you are likely to be regarded by them as someone they can trust. To be trusted is a vital factor in the care of the depressed: so this would give you confidence to do a follow-up when it seems necessary. In a strange kind of way, many people will already have regarded you as a sort of counsellor cum confidant. It would be sensitive and responsible for you to note any changes of behaviour or a marked chanbe in daily or weekly routines, those who stop gardening for no obvious reason; who are unwell;, especially those living alone: hints of stress or anxiety, especially following a robbery or loss; an aura of detachment: a change in their apperarance for the worse; a withdrawal or not being their usual friendly self.

How you respond to any one of these people who may be depressed is up to you. Here are a few guidelines which are essential for all of us to follow.

1 Listen; give the other person a bit of time; you may not have another opportunity.

2 Try to be accepting, whether you agree or not - let them express their needs, hopelessness, frustreations.

3 After you have given them some space, do not be afraid to respond with, 'You are having quite a time of it', or 'Everything seems to come at once -it all gets on top of one', If appropriate, make some positive comments - you are coping well - have a lot of patience, courage. You may consider it helpful to ask, 'Do you feel you can stand any more?', 'It's getting you down, isn't it?' 'Do you feel sort of lost?' 'Are you finding it hard to concentrate?' If the person answers yes directly or indirectly to these questions, you can assume they are depressed and maybe suicidal.

4 In this case try to stay with the situation and suggest help - go with them to where they can get help or make some definite arrangements for them. It is most important to be aware that the severely depressed find it hard to ask for help, and do not feel entitled to extra attention,. If it is impossible to mobilize help, the most valuable thing to offer is

the 'keep in touch' idea, which may make all the difference.

Togetherness and Professional Treatment.

Those who have a successful pick-up encounter will be ready to promote togetherness and possibly seek professional help if required. Now we have to help the depressed person to feel secure enough to take the big step of trusting and co-operating with the helpers. Let us look at two very common examples. Peter, a middle aged accountant, became very upset following the break up of his marriage. He had had a severe depressive attack two years before, lasting several months. A colleague from his office contacted the Samaritans and accompanied him to a local centre. He was seen by a female volunteer who initially was concerned to help reduce his emotional pain. She achieved this largely by listening intensely, accepting his grief and some expressions of anger. Peter said he had always depended upon his wife and he could not believe she had been having an affair with their neighbour. The Samaritan gave him permission, as it were, to be really upset. After nearly two hours he seemed calmer. By now the Samaritan had created a 'togetherness' with Peter: his problems were the same; the Samaritan offered no solutions, but three essential things had happened.

1 His boss, in a firm but decisive way, had told Peter that he must get some help and had gone with him.

2 The Samaritan befriended him, gave of herself in total attention with acceptance and patience.

3 He was now no longer facing his crisis alone.

This was only the beginning. Peter was getting very depressed and had been getting worse for the last three weeks: he could not eat or sleep; he was very agitated and felt a failure. Feeling more secure with Samaritan befriending, he agreed to see his GP. So the togetherness moves into the professional circle and Peter is given some appropriate medical help. The Samaritans continue to befriend, and so the circles overlap. He is becoming more able to assert himself, because those three helpers, the boss (gatekeeper), the Samaritans (support) and the doctor (professional treatment) helped to restore his self-confidence, and helped him to feel a person again.

Mary, a thirty year old housewife, has two children under five. She was becoming very depressed. She had had a bad time with her husband who had recently gone back to sea. Her mother was an in-patient in a psychiatric hospital many miles away and her father had killed himself when she was fourteen. The only good spot in the situation was her GP whom she had known for three years. Although the doctor had a very busy practice, Mary felt she always listened to her and she respected her wish to keep her children. She had established a togetherness, and because of this positive relationship, the bleak situation became bearable.

It is evident that so much of the future developments in all these encounters is dependent upon the quality of the relationship created between those involved. The great therapeutic value of the doctor/-patient relationship has always been recognised in medicine. However, putting it effectively into practice varies quite a lot. Depression is about feelings of hopelessness and despair, anger and anxiety - people in this state need time to unwind It is true that those suffering from depression will benefit from anti-depressants or psychological help, but they improve faster with good human support.

In conclusion, we should never underestimate the severity of the psychological pains caused by depression. Depression has many different causes and is expressed in a variety of ways. Hopefully, supportive befriending care, professional psychological treatment and, where appropriate, drug therapy, can all be made available as they can best meet the needs of those enveloped in depression.

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