DEPRESSION: IS IT AN ILLNESS?

by COLIN MURRAY PARKES

Depression is the emotion which accompanies the experience of helplessness and hopelessness. It is an experience which we have all had, though some are more prone to it than others. Depression is common after bereavement; it tends to be associated with social withdrawal and with feelings of apathy and tiredness. It occurs most often in the so-called third phase of grieving when the intensity of the pangs of grief begins to decide. This depression is not an illness, and people who experience it may need to be reassured of that fact.

Psychiatrists often use the term "depression" for "depressive illness", a particular syndrome (or group of symptoms) which are sometimes (but not often) triggered by bereavement. It is important to recognise this syndrome when it occurs, firstly because it causes great misery and may even lead to suicide, and secondly because it usually responds well to medical treatment. Any bereaved person who may be suffering from a depressive illness should therefore be referred to a doctor.

Although many people who develop a depressive illness will have had previous episodes, this is not always the case and the diagnosis is best made by seeking for evidence of two or more of the following symptoms:

KEY SYMPTOMS

1. **Retardation** of thought and movement. The sufferer thinks, speaks and moves in a sluggish way. Communication is like wading through treacle. Severe apathy, tiredness and inactivity accompany this symptom. In extreme form the patient may be mute and unresponsive.
2. **Early Morning Waking** such that the sufferer wakes at 3 or 4 a.m. and gets no more sleep.
3. **Diurnal Variation of Mood**—deep depression which is usually worse in the morning, but improves as the day goes on.
4. **Self-reproaches** which are sometimes so severe as to amount to delusions of guilt or sin. These are quite out of proportion to any just cause for guilt and become a major preoccupation.
5. **Anorexia**—interest in food, sex and all other appetites is lost.
6. **Weight Loss** follows from this and may be severe.

These symptoms can be remembered by their initial letters, R E D S A W. In addition, there is a variety of bodily symptoms which often accompany depressive illness and may become the focus of attention in the patient—they include constipation, aching body or limbs and indigestion.

MEDICAL TREATMENT

Although most people with depressive illness will eventually get better without treatment, the condition is so miserable and the danger of suicide so great that medical advice should always be obtained.

The main choice for the doctor lies between the prescription of antidepressant drugs, administration of electric convulsive therapy, and psychotherapy. It is sometimes advisable for the patient to be admitted to hospital for his or her own protection, but both methods of treatment can be given to outpatients, if appropriate.

Antidepressant drugs are usually effective, but they have two disadvantages: they take 7-21 days to work, and most of them have side effects which may cause the patient to stop taking them before they have been given a fair trial. These side effects may include drowsiness, dry mouth and dizziness (particularly when rising from a chair, etc.). They usually improve as the patient gets used to the medication and they seldom justify stopping it.

Some antidepressants are dangerous in overdose and potentially suicidal patients should not be provided with large quantities of these drugs.

Electric Convulsive Therapy (E.C.T.) is not as awesome as it sounds An electric shock to the brain is administered under general anaesthetic and the convulsion, which was an alarming feature in the early days, is now prevented by means of relaxant drugs. The risk is no greater than that of the general anaesthetic.

The great advantage of E.C.T. is that it is usually effective in relieving depression within a few days rather than weeks. In suicidal depression it can be life-saving.



Patients often complain of slight confusion and absent-mindedness during the first few hours after treatment. For this reason they need to be accompanied home if the treatment is being given to an outpatient. Absent-mindedness may persist for a few days.

Quite how E.C.T. works is still unknown. Recent research at Northwick Park Hospital has called in question the need for the convulsive fit and it may be that, in some cases, the anaesthetic itself is therapeutic. But the fact remains that most patients with depressive illness soon recover after E.C.T.

Psychological Treatments for Depression. The treatment of depressive illness by psycho-analysis remains controversial, but most psychiatrists would accept that less intensive forms of psychotherapy are a valuable adjunct to drug treatments or E.C.T. By "psychotherapy" I mean the kinds of "talking cure" which are used by psychiatrists and other members of the mental health care services. There are too numerous to be discussed here and their availability varies greatly from one district to another. Although it is usually assumed that psychotherapy is a much more sophisticated form of treatment than counselling, in practice the kind of supportive psychotherapy offered by most psychiatrists does not differ greatly from it. What one can expect from a psychiatrist is a full case history and psychiatric assessment, and this in itself can be very therapeutic. Thus a depressed patient may begin to feel much less helpless once he has helped the psychiatrist to take a "birds-eye view" of his problems.

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Recent research has claimed good results from the treatment of milder forms of depression by "Cognitive Behaviour Therapy". This aims to re-educate the patient by changing negative attitudes and hence enabling him or her to break out of a vicious circle of self-perpetuating helplessness. The treatment is highly structured, directive and takes 12 to 16 weeks. At the present time it is only available at a few centres.

OTHER TYPES OF DEPRESSION

Quite apart from depressive illness there are other circumstances in which bereavement counsellors should seek or refer depressed people for medical advice:

1. When there is a suicidal risk. The assessment of risk was considered in **Bereavement Care** Vol. 1, No. 1. The essential message is "Never be afraid to ask".
2. When there is an unusual degree of agitation, irrational threats or acts of violence towards others.
3. When the depression of bereavement does not seem to be moving towards resolution; the bereaved are "stuck" despite the support which they are receiving from the counsellor.

WHY DO SOME BEREAVED PEOPLE DEVELOP DEPRESSIVE ILLNESSES?

Current evidence points to a number of factors, any or all of which contribute to vulnerability:—

Learned Helplessness. Work by Seligman and Beck suggests that episodes of depressive illness occur when a situation arises in which a deep-seated assumption of helplessness is evoked A tendency towards helplessness is thought to be learned during childhood (Bowlby, 1980) and Brown's studies indicate that the death of a parent is particularly likely to evoke such feelings These are then likely to return following other losses later in life.

Biochemical Factors. Pleasure and pain centres in the brain are activated by nerve impulses and sensitised by complex enzyme systems. Individual differences in prevailing mood and vulnerability to depression are thought to reflect individual differences in brain structure and function. Hence a tendency to depression may be an inherited characteristic.

The success of antidepressant medication arises from interference with the enzyme systems that mediate depression.

Psychoanalytic Theory. Freud claimed that the main difference between "mourning" (i.e. normal grief) and "melancholia" (depressive illness) is the existence in the melancholic of self-reproaches which would be more appropriately directed against the lost person. He believed that ambivalence towards a significant person, usually a parent, is repressed and introjected (directed inward against the self) when that person is lost. Such feelings thenceforth remain liable to re-emerge in the form of a depressive illness following subsequent losses or threats of loss.

Social Factors. Brown's studies have shown that social factors influence a person's vulnerability to depression in the face of loss and change. These include the absence of an intimate person in whom to confide and the imperative need to care for small children in the absence of adequate resources (as in the case of working class mothers with no job outside the home). Each of these can be seen as increasing feelings of helplessness and hopelessness.

WHAT TO DO

Express your concern to the bereaved person for their welfare and assure them that they can be helped. Explain why you will be contacting their G.P. and their family. Don't ask their permission to do this—they may not be in a fit state of mind to make a valid judgment and you don't want to have to disobey if permission is refused. Discuss the situation with your supervisor and decide what further help you are in a position to offer. Contact the G.P. and explain the situation. Whenever it seems appropriate, offer to remain in touch with the client; now is not the moment to withdraw your support. The bereaved person may need encouragement to go through with treatment or to accept hospital admission. It helps them to have someone to discuss it with. Similarly, you may need to rally the family in support and to explain things to them. If you are dissatisfied with the help given by a doctor or have any doubts about the situation, discuss the case with a psychiatrist (perhaps the Branch's psychiatric adviser). Whenever there are children living at home it is important to ensure that they are being adequately cared for. A local social worker may need to be consulted, family aids drawn in, relatives and friends rallied in order to relieve some of the stress on the parent as well as supporting the children. Children often benefit from participating in family meetings in which their needs are recognised as well as those of a depressed parent. This aspect of family care is often forgotten by doctors who tend to see the patient as their sole responsibility.

MYTHS ABOUT DEPRESSION AFTER BEREAVEMENT

The following popular misconceptions are *not* supported by research:

1. "Those who threaten suicide, don't do it".—**They do!**
2. "Valium is a good treatment for depression".—**In fact it may make it worse!**
3. "Antidepressant drugs impair the grieving process and should never be prescribed after bereavement".—**There is no evidence that antidepressants do harm after bereavement.**
4. "Depressive illness is 'endogenous'; it is not caused by bereavements and other life events".—**Brown's studies have disproved this.**
5. "Physical treatments are ineffective when depressive illnesses follow psychological trauma (such as bereavement)".—**In fact most depressive illnesses do follow psychological trauma and do respond to treatment.**
6. "People who are taking drugs will not benefit from psychotherapy or counselling".—**Untrue. Drugs often make counselling possible by freeing people from depressive symptoms.**
7. "Bereaved people who get depressed are wallowing in misery and should be told firmly to 'snap out of it".—**Nonsense. Depression is so unpleasant that nobody would "wallow" in it or fail to 'snap out of it' if they could.**

Future Reading

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have suffered the loss of a relative or friend, but nevertheless she will need help in coming to terms with the death of a parent. A teenager is old enough to worry about practical matters: whether there will be enough money for the family to live on, whether they will have to move house and whether she will be expected to look after the surviving parent for the rest of her own life. She will also want desperately to comfort that parent, but may well be at a loss as how to go about it. It is almost impossible for the mother/father to instil confidence into a bewildered child while trying to face his or her own grief and cope with other problems. In Dr. Black's words, "Bereaved children find themselves alone with a tearful, withdrawn parent whom they cannot contact or comfort and who no longer appears to meet their needs. The conspiracy of silence ran be bewildering."

A friend in need

It may need the help of someone outside the immediate family to sit down with the child and reassure her about practicalities and explain that the remaining parent *will* gradually recover and return to normal. Close friends can play a useful role in encouraging all members of the family to express their sadness and to help them communicate with each other. They can try to ensure that family life continues as normally as possible by bringing a little cheer and fresh air into the household. The important thing to remember, for parent, relative or friend, is that children need to talk about death, to ask questions and express all their feelings and emotions. A frank discussion will enable the family to share their grief, to dispel anxiety and anger and to keep alive the happy memories. It may be that a bereavement, despite the immediate misery it causes, will bring a family closer together.

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She becomes, however unwarrantably, someone who might be a predator. Many widows will attest to this phenomenon.

Widowed people of both sexes need to be able to start new relationships, to experiment and to make mistakes, to pull in their horns and to venture out again, without being worn down by criticism from families, friends or children. Counsellors can be a staunch and vital support for widowed people in these situations.

As counsellors, we should be aware of both this need, and the need to talk about it. We must emphasise that there is no shame in these feelings, and that as other relationships are entered into, the sexual need will probably diminish to a certain extent. Yet it may not necessarily be so. Everyone is different, and so is their sexual drive and need. It therefore follows that no two bereaved people will react in the same way.

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MEMORIALS TO THOSE WHO HAVE BEEN CREMATED

A competition called the **Phoenix Awards Scheme** has been set up to stimulate ideas and original thinking on the design of monuments and memorial gardens for commemoration after cremation. For the winner, there is a trophy designed by Stephen Hines, and a cash prize of £1,000. The judges include a crematorium superintendent, a clinical psychologist, an architect, a monumental sculptor, a landscape designer, a clergyman and a committee member of the Victorian Society. The closing date is 31st July, 1985. Official entry forms are available from: The Memorial Advisory Bureau, 139 Kensington High Street, London W18 6SX. Tel. 01-937 0052. (send £5 non-returnable deposit).

Front page picture: A Gentleman with his 2 children (usually called "The Widower") by Moroni. Courtesy National Gallery of Ireland.