OVERCOMING DEPRESSION

The Curse of the Strong

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Introduction

'Oh, no! It's Monday morning. I don't want to get up. It's too early, the week is too long, I've got too much work to do and I need a holiday. I feel so depressed!'

Every Monday starts this way and I refuse to rise until I am running late, but after a while I drag myself grumpily out of bed and start my week.

I have never been good at Mondays and it takes a while for my mood to pick up through the day. It isn't that I don't like my job; I do, very much. It is just that I like rest and recreation even more and on a Monday morning the next opportunity for these pleasures seems an awfully long way away.

Everyone has suffered spells of low mood of this type at some time or other and some people think that this means everyone has suffered from depression. It doesn't, or at least, not *clinical depression* or *depressive illness*. The truth is that clinical depression is a horrible illness of which most of us, thank goodness, have not the faintest inkling. This is one of the many trials sufferers from the illness have to face: people looking at them knowingly and saying, 'Oh, yes, I've often had that. I find the best thing is just to pull myself together and get busy.'

No you haven't, so stop making things worse with your ill-informed advice. If you really want to help, try to understand that the sufferer of this illness is going through torment of a pretty awful kind. Among the descriptions of the experience of depressive illness that have impressed me are: 'It's like falling down a well with no bottom; the blackness surrounds you and the tiny circle of light gets ever smaller till it disappears', and 'It is being trapped in hell, with no comfort, no salvation and no hope.' Some Monday morning! To have the enormity of this experience understood may at least reduce the loneliness. That will mean a lot.

Part of the problem is in the name. Depression sounds like how I feel on a Monday morning, but in reality it isn't even close. The one is a relatively mild and transient disturbance of emotion, the

other a serious illness causing immense suffering. When I'm in my more expansive moods, I would like to call it 'Cantopher's disease', as that sounds like a really serious condition, but if I did I think my colleagues would believe that I had finally gone over the edge into delusions of grandeur. The point, though, is a crucial one; the most important key to recovering from this illness is understanding that it is one.

There are many pieces of unhelpful advice to which sufferers of depressive illness are prone to be exposed. The commonest and possibly the worst is: 'Pull yourself together.' If I had a dollar for every time a patient of mine has had this nonsense, I'd be Bill Gates. And it's so pointless. If the sufferer could have pulled himself together he would have done so ages ago. As you will read later, he is not the type to shirk challenges. In any case, what was the object of this stunning gem of advice? Do you really think he is going to put his hand to his brow and gasp: 'Gosh, thank you so much, I hadn't thought of that. Thank goodness you told me; I'll just go off and sort myself out and then everything will be fine'? I think not.

Beware, your advice can hurt and can potentially do serious harm. Better not to give any direction at all if you aren't sure. Understanding, patience and sympathy are in any case much more valuable commodities than even well-informed advice.

It is ironic that it is often the most loving friends and family who give the worst advice. They mean well and are calling from their own experience in their exhortations. 'Come on, get yourself going, get more interests, make more friends, get out more, let me show you how to have a good time.'

If you take this advice, good common sense though it seems to be, you will get much worse. But of course, it isn't just others who cause problems with their ignorance of this illness, it is also the sufferers themselves. I frequently find patients treating themselves with a harshness of a level they would never consider inflicting on anyone else. The guilt and self-loathing is in part a symptom of the illness, but in part it is also a cause of it. So stop condemning yourself for having the illness and don't make statements about yourself that you wouldn't make about another person. Would you say about a friend who was suffering from a severe and debilitating

illness: 'Look at her, she is so weak and lazy, it's pathetic. She should get a grip and stop being so feeble!' I don't think so. Well, if unfair condemnation of the afflicted isn't right about others, it is wrong for you too. So stop it and show yourself some understanding. A start will be finding out about what your illness really is.

The rest of us, then, happily don't know how it feels to suffer from clinical depression. But what is this illness, who gets it, why does it happen and what can be done? This book will seek to answer these questions, though I must stress that I am writing only about one form of depression: that is, stress-induced depressive illness. Some of what I say doesn't apply to manic depressive illness (or bipolar affective disorder), to depression relating to bereavement, to depression complicating other illnesses, postnatal depression, Seasonal Affective Disorder (SAD), or to depression as part of long-term personality problems. These are separate afflictions with their own body of excellent literature and I will deal with them only in passing. Having said this, depression from whichever source responds well to many of the strategies outlined here, so if you suffer from one of these conditions, please do read on.

You won't find here a comprehensive account of all the different ways that depressive illness has been viewed and explained; I have included only theories and treatments that I think make sense. What you will find is the sum of what my patients have taught me and, as they're an impressive bunch of people, I think we can learn from their wisdom, experiences and mistakes. This doesn't mean they are all super-intelligent high-fliers; far from it. Most of the people who I have treated with this condition have earned my admiration and respect, but this has been for a range of different achievements. A mother who tries her best for her five children on welfare or a refugee coping with the hostility of his neighbors while busting a gut for his family are as much at risk of this illness as the president of Oxfam. What they have in common is what this book is about, and I love them for it.

One more thing. If you are in the middle of a severe depressive illness, you won't be able to concentrate for long. Don't try to read more than a page or two at a time. You will forget a lot, so re-read

what you need to. **Concentrate on Chapters 1 and 5** for now. You can read the rest when you're a bit better and can concentrate for longer. Before we start, though, take heart. *People recover from depressive illness and can stay well if they make the right choices.*

1

What Is Depressive Illness?

There are a lot of different ways of looking at depressive illness. I will touch on some of these in Chapter 3, but for now I want to focus on what I believe to be the most important aspect of it, which is this: depressive illness is not a psychological or emotional state and is not a mental illness. It is not a form of madness.

It is a physical illness.

This is not a metaphor; it is a fact. Clinical depression is every bit as physical a condition as pneumonia, or a broken leg. If I were to perform a lumbar puncture on my patients (which, new patients of mine will be pleased to hear, I don't) I would be able to demonstrate in the chemical analysis of the cerebro-spinal fluid (the fluid around the brain and spine) a deficiency of two chemicals. These are normally present in quite large quantities in the brain, and in particular in one set of structures in this organ.

The structures concerned are spread around various parts of the brain, but are linked in the form of a circuit. This circuit is called the *limbic system*.

The limbic system controls a lot of the body's processes, such as sleeping–waking cycles, temperature control, temper control, eating patterns and hormones; every hormone in the body is directly or indirectly under the control of the limbic system. It keeps all of these functions in balance with each other.

Any electrical engineer reading this book will know of the concept of a 'reverberating circuit'. You find one of these at the core of any complex machine. For example, if a jumbo jet runs into a side wind, the pilot has to turn the tail flap to compensate, but this then means that the attitude of the wing flaps has to be changed to compensate to prevent the plane from falling out of the air. This in turn will affect the thrust required from the engines, and so on. So one change has knock-on implications for a host of different parts of the plane, far removed from each other. Something is required to

orchestrate the functioning of the whole machine to compensate for changes and keep the various different parts and functions in balance. That something is a reverberating circuit, which is an electrical circuit with lots of inputs and outputs. It enables every part of the machine to 'talk to' every other and compensate appropriately when changes are needed. It is essentially a giant thermostat, controlling many functions at once.

The limbic system is a reverberating circuit. As well as controlling all of the functions I have already mentioned, its most important function is to control mood.

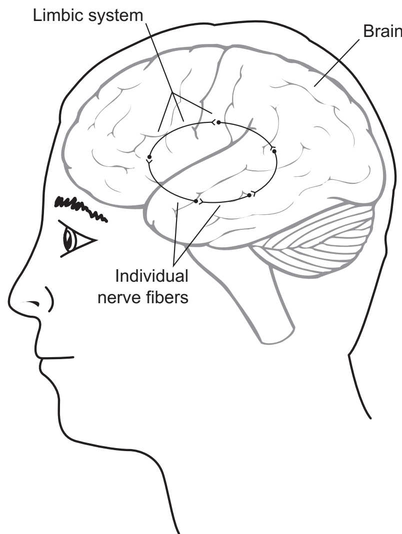

Figure 1 The limbic system

This simplified diagram shows one chain of nerve fibers. The whole system consists of millions of such chains with complex inputs and outputs which are not shown.

It normally does this remarkably well. A human being's mood is usually very stable, given what we all go through, coming back to normal quite quickly after the ups and downs of life. We must exclude bereavement here, which is a separate process, lasting much longer than the normal time it takes for the body to adapt to major events. For everything else, mood returns to normal after a short time. For example, if you win a million dollars on *Who*

Wants to Be a Millionaire?, or the lottery, or a football pool, your mood does indeed rise, for a few days. It then returns to normal, with occasional peaks, mostly in the first few weeks, corresponding with buying your first Ferrari and the like. But at 3:30 on a Tuesday afternoon, a few weeks on, your mood is no different than it was before the life-changing event occurred.

So mood isn't controlled consistently by events or the quality of your life, but by the limbic system. It is this circuit that determines, in the long term, the level of your mood. It is, if you like, the body's 'mood thermostat'.

But like every other system and structure in the body, it has a limit. If you bash a bone hard and consistently enough, it will break. So will the limbic system.

It can be caused to malfunction by a number of different factors. These include viral illnesses such as the flu. Most of us have experienced a degree of post-viral depression. It is very unpleasant and debilitating, but normally passes quite quickly. Sometimes it does not and leads to a fully blown clinical depressive episode. Incidentally, don't confuse this with 'chronic fatigue syndrome' or myalgic encephalopathy (ME), which is a separate and very nasty condition, though it also tends to follow viral illnesses.

Other precipitants of limbic system dysfunction are hormonal conditions, illicit drugs, too much alcohol, some prescribed medicines, too many major life changes, too many losses or facing choices involving conflicting needs.

By far the commonest trigger, though, is stress.

Whatever the cause, the end result is the same. If the limbic system is taken beyond its design limits, it will malfunction. The part of it that goes is the gap between the end of one nerve and the beginning of another, or the *synapse*. There are millions of these in the limbic system and they are the most vulnerable part of the circuit. A nerve fiber is essentially a cable. Once a nerve impulse starts down a nerve fiber, it reaches the end without difficulty; the tricky bit is getting the impulse across the synapse. This is done by the first nerve releasing chemicals into the synapse in response to the arrival of an impulse at its end. These chemicals travel across the synapse and when a sufficient quantity of them arrives at the beginning of the next nerve fiber, an impulse is triggered off.

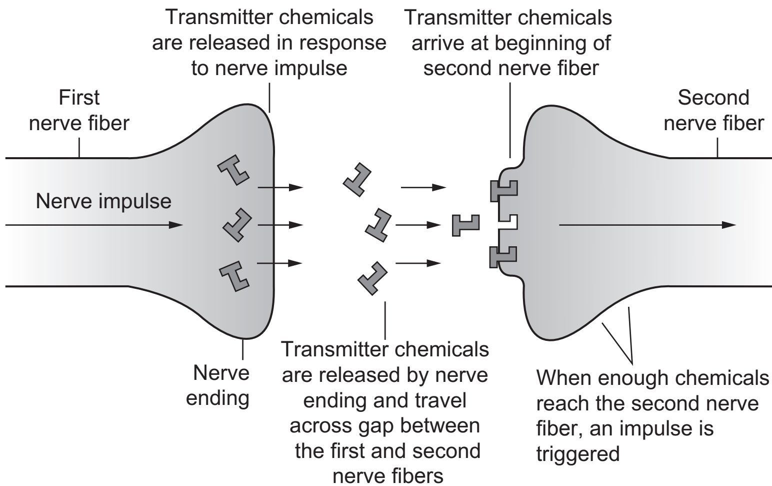

Figure 2 A synapse in the limbic system

Thus the gap is crossed by the nerve impulse and the circuit keeps running.

In clinical depression it is these *transmitter chemicals* which are affected. In response to stress or any of the other triggers, the levels of these chemicals in the synapses of the limbic system plummet (and the nerves probably get less sensitive to the chemicals, too). As yet we don't know for sure why this occurs, but it does, and when it does the circuit which is the limbic system grinds to a halt.

The transmitter chemicals thought to be involved are serotonin and noradrenaline, with two other chemicals, dopamine and the hormone melatonin, more recently discovered also to be in the picture. The truth is we don't know for certain how these chemical and nerve systems work. The more we learn about the limbic system, the more we realize we don't know. Isn't that always the way? Nonetheless, it is still clear that chemical changes in the limbic system are important in the development of depression.

When the limbic system malfunctions, a characteristic set of symptoms arises. These symptoms are what define clinical depression and separate it out from other states, such as sadness, disgruntlement or stress. There are some conditions, such as glandular fever, an underactive thyroid gland or ME, in which some of the symptoms are the same and someone under a lot of stress may

have some of them; but if you have all or nearly all of them, you have clinical depression. Most of these symptoms are under the heading of 'loss of'. It's pretty much a case of loss of everything – it is as if the whole body shuts down and, as I will outline later, this is possibly what is happening.

Symptoms in Clinical Depression

Feeling worse in the morning and better as the day goes on. Loss of:

- sleep (usually early morning waking)*
- appetite*
- energy
- enthusiasm
- concentration
- memory
- confidence
- self-esteem
- sex drive
- drive
- enjoyment
- patience
- feelings
- hope
- love
- and almost anything else you can think of.

* These can occasionally be increased, rather than decreased.

The symptom of feeling worse in the morning is a particular 'marker' for depressive illness and is caused by a hormonal change. Under normal circumstances the level of the hormone cortisol fluctuates through the day, with a high peak in the early morning and a gradual falling-off through the day until, by the evening, there is very little in circulation. However, in depressive illness, this morning peak is lost. In some people with depressive illness, other disturbed patterns of cortisol levels occur – and in fact over a 24-hour period cortisol levels in the blood tend to be raised – but in any case the normal fluctuation in levels through the day does not occur and it is this loss of the usual fluctuation, which the body

expects, that seems to cause the problem. Thus you feel worse in the morning. This is one demonstration, if there were any doubt, that depressive illness really is physical. There are some researchers who see a rise in cortisol as being more central and even the real cause of depressive illness, disrupting circadian rhythms and thus stopping normal functioning (see Hibernation, p. 28).

The loss of memory experienced by sufferers of this illness is, in fact, apparent rather than real. What actually happens is that you can't concentrate during a depressive episode, so you don't take information in properly. Therefore the information isn't available later to recall, as it hasn't got into the memory store in the first place. In fact, the evidence is that once memories are laid down, they aren't significantly affected by the onset of depression.

One more important fact: depressive illness, or at least the commonest form, which is that caused by stress, nearly always happens to one type of person. So much so, in fact, that it allows me my little party piece in interviews with patients, which is to tell them about their personality before they tell me. Normally, in a psychiatric assessment, one is expected to make enquiries about aspects of the patient's personality. I never bother, because it is nearly always the same. He or she will have the following personality characteristics:

- (moral) strength
- reliability
- diligence
- strong conscience
- strong sense of responsibility
- a tendency to focus on the needs of others before one's own
- sensitivity
- vulnerability to criticism
- self-esteem dependent on the evaluation of others.

This person is the sort to whom you would turn if you had a problem to sort out upon which your house depended. She is a safe pair of hands and you can trust her with your life. Indeed, this person is usually admired, though often somewhat taken for granted by those around her. People are usually very surprised when she gets ill; indeed, she is the last person you would expect to have a breakdown.

But it isn't so surprising when you consider that depressive

illness is a physical condition. Think about it; give a set of stresses to someone who is weak, cynical or lazy and he will quickly give up, so he will never get stressed enough to become ill. A strong person, on the other hand, will react to these pressures by trying to overcome them. After all, she has overcome every challenge she has faced in the past through diligence and effort. So she keeps going, absorbing more and more, until, inevitably, symptoms emerge. At this point most people would say, 'Hang on, this is ridiculous, I'm doing too much, I'm getting symptoms! You're going to have to help; it's about time you pulled your weight, and as for you, you're going to have to sort yourself out.' So they pull back from the brink before it is too late. But the sensitive person, without a very solid sense of self-esteem, can't stop struggling, because she fears other people being disappointed in her. Even more than this, she fears being disappointed in herself. So she keeps going, on and on and on, until suddenly: BANG! The fuse blows.

That is what this is: a blown fuse. Again, this isn't a metaphor. The limbic system is a type of fuse mechanism and when it blows, it doesn't matter how hard you try, you can't achieve anything. Once the fuse has blown, you can put 1,000 amps through it, but it won't do any good.

So turn the electricity off.

I will return to this point later, but the point to hold on to now is that you are wrong in thinking you are weak and that you should be ashamed to have contracted this illness. *You have got it because you are too strong*. You are in good company. This is the affliction of the good and the great. These are a handful of those who have suffered from it:

- Oliver Cromwell
- Abraham Lincoln
- Isaac Newton
- Edgar Allan Poe
- Ludwig van Beethoven
- Vincent Van Gogh
- Winston Churchill
- Evelyn Waugh
- Ernest Hemingway
- Tony Hancock