Paul Gilbert is Professor of Clinical Psychology at the University of Derby and Director of the Mental Health Research Unit, Derbyshire Mental Health Trust. He is a visiting professor at the Universities of Fribourg (Switzerland) and Coimbra (Portugal) and a fellow of the British Psychological Society. Between 2002 and 2003 he was President of the BABCP. Paul is the author of *The Compassionate Mind*, also published by Constable & Robinson.

The aim of the **Overcoming** series is to enable people with a range of common problems and disorders to take control of their own recovery program. Each title, with its specially tailored program, is devised by a practising clinician using the latest techniques of cognitive behavioral therapy – techniques which have been shown to be highly effective in changing the way patients think about themselves and their problems.

The series was initiated in 1993 by Peter Cooper, Professor of Psychology at Reading University and Research Fellow at the University of Cambridge in the UK whose original volume on overcoming bulimia nervosa and binge-eating continues to help many people in the USA, the UK and Europe.

Titles in the series include:

OVERCOMING ANGER AND IRRITABILITY
OVERCOMING ANOREXIA NERVOSA
OVERCOMING ANXIETY
OVERCOMING BODY IMAGE PROBLEMS
OVERCOMING BULIMIA NERVOSA AND BINGE-EATING
OVERCOMING CHILDHOOD TRAUMA
OVERCOMING CHRONIC FATIGUE
OVERCOMING CHRONIC PAIN
OVERCOMING COMPULSIVE GAMBLING
OVERCOMING DEPERSONALIZATION AND FEELINGS OF UNREALITY
OVERCOMING DEPRESSION
OVERCOMING GRIEF
OVERCOMING INSOMNIA AND SLEEP PROBLEMS
OVERCOMING LOW SELF-ESTEEM
OVERCOMING MOOD SWINGS
OVERCOMING OBSESSIVE COMPULSIVE DISORDER
OVERCOMING PANIC
OVERCOMING PARANOID AND SUSPICIOUS THOUGHTS
OVERCOMING RELATIONSHIP PROBLEMS
OVERCOMING SEXUAL PROBLEMS
OVERCOMING SOCIAL ANXIETY AND SHYNESS
OVERCOMING TRAUMATIC STRESS
OVERCOMING WEIGHT PROBLEMS
OVERCOMING WORRY
OVERCOMING YOUR CHILD'S FEARS AND WORRIES
OVERCOMING YOUR CHILD'S SHYNESS AND SOCIAL ANXIETY
OVERCOMING YOUR SMOKING HABIT

All titles in the series are available by mail order.
Please see the order form at the back of this book.
www.overcoming.co.uk

OVERCOMING DEPRESSION

A self-help guide using Cognitive Behavioral Techniques

PAUL GILBERT

ROBINSON
London

Constable & Robinson Ltd
3 The Lanchesters
162 Fulham Palace Road
London W6 9ER
www.constablerobinson.com

First published in the UK by Robinson,
an imprint of Constable & Robinson Ltd 1997

A copy of the British Library Cataloguing in Publication Data is available from the British Library.

Important Note

This book is not intended as a substitute for medical advice or treatment. Any person with a condition requiring medical attention should consult a qualified medical practitioner or suitable therapist.

ISBN 978-1-84901-066-5

Printed and bound in the EU

1 3 5 7 9 10 8 6 4 2

Table of contents

Acknowledgments

The Mental Health Research Unit was set up in 1996 as a joint project between the University of Derby and what is now the Derbyshire Mental Health Services NHS Trust. I am extremely grateful for their vision and support in our work. The Mental Health Research Unit continues to seek research funds and engage in research into mental health difficulties. There are many people in my unit I would like to thank. Special thanks go to Corinne Gale (research psychologist and research coordinator) and Kirsten McEwan (research psychologist and statistician) for their extraordinary dedication, hard work and wonderfully friendly dispositions. Special thanks also go to Lesley Futter for her hard work with this manuscript and with the Mental Health Research Unit. Thanks also to our super-efficient Kelly Sims who has just joined us. We are deeply indebted to Keith Wilshere for his skilful management of our unit, encouragement on the compassion projects, and keeping us all afloat, as well as his brilliant bass playing and technical skills for Still Minds.

Thanks to Sue Procter for her help in our first study of compassion-focused group therapy. Thanks also to psychologists Sharon Pallant, Michelle Cree and Andrew Rayner for their compassion-focused in-patient work. Two years ago some colleagues and I also set up a charity which has the mission statement 'To

promote well-being through the scientific understanding and application of compassion'. If you go to the website at *www.compassionatemind.co.uk*, you will find lots of information, and you can download several of our publications. Key people have been fundamental to the development and support of this project, and special thanks go to my friend of over 30 years, Chris Gillespie. I would also like to thank the other board members: Chris Irons, Ken Goss, Mary Welford, Ian Lowens, Deborah Lee, Thomas Schroder and Jean Gilbert. Thanks to Diane Woollands for her skilful management of the website and board.

The University of Derby Psychology Department has been supportive, and thanks go to James Elander and in particular Frances Maratos for her support and expertise in fMRI, and enthusiasm for further studies on compassion with the universities of Aston and Glasgow. We are very excited about these studies; find out more on our website. Thanks also to Michael Townend for his enthusiasm and support for compassion-focused therapy. I would also like to thank Bob Leahy of the International Association of Cognitive Behavioral Therapists for his friendship and scholarship. I am also delighted to be able to thank the British Association for Behavioural and Cognitive Psychotherapies for their openness, support, friendliness and putting up with a quirky, evolutionary, archetype- and compassion-focused dude like me.

Nick Robinson and his staff at Constable & Robinson have been tireless in working to advance this series. They have been lovely to work with and special thanks go to Nick himself, Fritha Saunders for her soothing, and Eryl Humphrey Jones.

Last but of course not least, many thanks to my supportive family, Jean, Hannah and James, perhaps the biggest antidote to depression.

I would like to dedicate this book to all depressed people: may compassion help you light a candle in your darkness. I offer my immense gratitude to all those depressed people who have been honest and open and have educated and guided me in my therapeutic efforts.

Foreword

Many, perhaps the majority, of those who go to see their family doctor have some type of psychological problem which makes them anxious or unhappy. There may be a fairly obvious reason for this – the loneliness of widowhood or the stresses of bringing up a family – or it may be that their mental state is part of their personality, something they were born with or a reaction to traumatic experiences in their lives. Despite being so common, I soon discovered after starting in general practice over ten years ago that this type of mental disturbance (usually described as a *neurosis* to distinguish it from the *psychosis* of those with a serious mental illness like schizophrenia) is particularly difficult to deal with. What are the options? Well, there are always drugs – minor tranquillizers, antidepressants and sleeping pills. It is certainly easy enough to write a prescription and more often than not the patient feels a lot better as a result, but there is no getting away from the fact that drugs are a chemical fix. Sometimes this is all that is necessary to tide someone over a difficult period, but more usually the same old problems recur when the drugs are discontinued.

The alternatives to drugs are the 'talking therapies' ranging from psychoanalysis to counselling that seek to sort out the underlying cause of anxiety or unhappiness. Psychoanalysis is out of the question for many, being too prolonged – often lasting

for years – and too expensive. Counselling certainly can be helpful for no other reason than that unburdening one's soul to a sympathetic listener is invariably therapeutic. But once the counselling sessions were over, I got the impression it was only a matter of time before the psychological distress reappeared.

Here, then, is one of the great paradoxes of modern medicine. Doctors can now transplant hearts, replace arthritic hips and cure meningitis but, confronted by the commonest reason why people seek their advice, they have remarkably little to offer. And then a couple of years ago I started to hear about a new type of psychological treatment – cognitive therapy – which, it was claimed, was not only straightforward but demonstrably effective. I was initially sceptical as I found it difficult to imagine what sort of breakthrough insight into human psychology should lie behind such remarkable claims. The human brain is, after all, the most complex entity in existence, so it would seem unlikely that someone had suddenly now at the end of the twentieth century found the key that unlocked the mysteries of neuroses – a key that had eluded human understanding for hundreds of years.

The central insight of cognitive therapy is not, it emerges, a new discovery, but rather is based on the profound observation originally formulated by the French philosopher Descartes that the essential feature of human consciousness was 'cogito ergo sum' – 'I think therefore I am.' We *are* our thoughts and the contents of our thoughts have a major influence on our emotions. Cognitive therapy is based on the principle that certain types of thought that we have about ourselves – whether, at its simplest, we are loved or wanted or despised or boring – have a major effect on the way we perceive the world. If we feel unloved, the world will appear unloving, and then every moment of every day our sense of being unloved is confirmed. That, after

all, is what depression is all about. These types of thoughts are called 'automatic thoughts' because they operate on the margins of our consciousness as a continual sort of internal monologue. If these thoughts are identified and brought out into the open then the state of mind that they sustain, whether anxiety or depression or any of the other neuroses, can begin to be resolved.

So this type of therapy is called 'cognitive' because it is primarily about changing our thoughts about ourselves, the world and the future. The proof of the pudding, as they say, is in the eating and the very fact that this type of therapy has been shown to work so well, in countless well-controlled studies, is powerful confirmation that the underlying insight that our thoughts lie behind, and sustain, neurotic illnesses is in essence correct.

Nonetheless, some may be forgiven for having misgivings. The concept of cognitive therapy takes some getting used to and it is certainly hard to credit that complex psychological problems can be explained by such an apparently simple concept. There is perhaps an understandable impression that it all sounds a bit oversimplified or trite, that it fails to get to the root cause of the source of anxiety or depression.

So it is necessary to dig a bit deeper to examine the origins of cognitive therapy and perhaps the easiest way of doing this is to compare it with what for many is the archetype of all forms of psychotherapy – psychoanalysis. Psychoanalysis claims to identify the source of neuroses in the long-forgotten and repressed traumas of early childhood, so it is less concerned with thoughts themselves than with the hidden meaning which (it claims) underlies them. The important question, though, is whether psychoanalysis does make people better, or at least less unhappy. Many people certainly believe they have been helped, but when Professor Gavin Andrews of the University of New

South Wales reviewed all the studies in which the outcome of psychoanalysis had been objectively measured in the *British Journal of Psychiatry* in 1994, he was unable to show that it worked any better than 'just talking'.

In cognitive therapy, the importance of human thoughts lies precisely in their content and how that influences the way a person feels about themselves, a point well illustrated by one of its early pioneers, Aaron Beck. Back in the sixties, while practising as a psychoanalyst in Philadelphia, Beck was treating a young woman with an anxiety state which he initially interpreted in true psychoanalytic fashion as being due to a failure to resolve sexual conflict arising from problems in childhood. During one session he noticed that his patient seemed particularly uneasy and, on enquiring why, it emerged she felt embarrassed because she thought she was expressing herself badly and that she sounded trite and foolish. 'These self-evaluative thoughts were very striking,' Beck recalled, 'because she was actually very articulate.' Probing further he found that this false pattern of thinking – that she was dull and uninteresting – permeated all her relationships. He concluded that her chronic anxiety had little to do with her sex life but rather arose from a constant state of dread that her lover might desert her because he found her as uninteresting as she thought herself to be.

Over the next few years, Beck found that he was able to identify similar and quite predictable patterns of thinking in nearly all his patients. For the first time he realized that he was getting inside his patients' minds and beginning to see the world as they experienced it, something he had been unable to do in all his years as a psychoanalyst. From that perspective he went on to develop the principles of cognitive therapy.

Compared to psychoanalysis, cognitive therapy certainly does appear much simpler, but we should not take this to mean that

it is less profound. The central failure of the founders of psychoanalysis was that they did not recognize the true significance of thoughts in human neurosis. Once that significance was grasped by those like Aaron Beck then human psychological disorders became more readily understandable and therefore simpler, but it is the simplicity of an elegant scientific hypothesis that more fully explains the facts. It can't be emphasized too strongly the enormous difference that cognitive therapy has made. Now it is possible to explain quite straightforwardly what is wrong in such a way that people are reassured, while allowing them to be optimistic that their problems can be resolved. Here, at last, is a talking therapy that works.

Professor Gavin Andrews in his review in the *British Journal of Psychiatry* identified cognitive therapy as 'the treatment of choice' in generalized anxiety, obsessive compulsive disorders and depression. It has in addition been shown to be effective in the treatment of eating disorders, panic attacks and even in the management of marital and sexual difficulties, in chronic pain syndromes and many emotional disorders of childhood. Its contribution to the alleviation of human suffering is remarkable.

James Le Fanu, GP

Introduction

Why a cognitive behavioral approach?

The approach this book takes in attempting to help you overcome depression is a 'cognitive-behavioral' one. A brief account of the history of this form of intervention might be useful and encouraging. In the 1950s and 1960s a set of therapeutic techniques was developed, collectively termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes (traditionally the focus of psychoanalysis, the approach developed by Sigmund Freud and his associates). Second, they were scientifically based, in the sense that they used techniques derived from what laboratory psychologists were finding out about the mechanisms of learning, and they put these techniques to scientific test. The area where behavior therapy initially proved to be of most value was in the treatment of anxiety disorders, especially specific phobias (such as extreme fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that many patients were experiencing. In

particular, behavior therapy proved inadequate when it came to the treatment of depression. In the late 1960s and early 1970s a treatment for depression was developed called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck. He developed a theory of depression which emphasized the importance of people's depressed styles of thinking, and, on the basis of this theory, he specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

The techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a therapeutic approach which has come to be known as 'cognitive behavioral therapy' (or CBT). This therapy has been subjected to the strictest scientific testing and has been found to be highly successful for a significant proportion of cases of depression. In recent years, one variation on CBT for depression has been the introduction of 'mindfulness' techniques. Another has been the appreciation of the importance of compassion in overcoming depression. Both of these innovations are dealt with extensively within this new edition of *Overcoming Depression*.

It has now become clear that specific patterns of disturbed thinking are associated with a wide range of psychological problems, not just depression, and that the treatments which deal with these are highly effective. So, effective cognitive behavioral treatments have been developed for a range of anxiety disorders, such as panic disorder, generalized anxiety disorder, specific phobias, social phobia, obsessive compulsive disorders, health anxiety, as well as for other conditions such as drug addictions, and eating disorders like bulimia nervosa. Indeed, cognitive behavioral techniques have been found to have an

application beyond the narrow categories of psychological disorders. They have been applied effectively, for example, to helping people with weight problems, couples with marital difficulties, as well as those who wish to give up smoking or deal with drinking problems. They have also been effectively applied to dealing with low self-esteem.

The starting-point for CBT is the realization that the way we think, feel and behave are all intimately linked, and changing the way we think about ourselves, our experiences, and the world around us changes the way we feel and what we are able to do. So, for example, by helping a depressed person identify and challenge their automatic depressive thoughts, a route out of the cycle of depressive thoughts and feelings can be found. Similarly, habitual behavioral responses are driven by a complex set of thoughts and feelings, and CBT, as you will discover from this book, by providing a means for the behavior, thoughts and feelings to be brought under control, enables these responses to be undermined and a different kind of life to be possible.

Although effective CBT treatments have been developed for a wide range of disorders and problems, these treatments are not currently widely available; and, when people try on their own to help themselves, they often, inadvertently, do things which make matters worse. In recent years, experts in a wider range of areas have taken the principles and techniques of specific cognitive behavioral therapies for particular problems and presented them in manuals (the *Overcoming* series) which people can read and apply themselves. These manuals specify a systematic program of treatment which the person works through to overcome their difficulties. In this way, cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

The use of self-help manuals is never going to replace the need for therapists, and many people with emotional and behavioral problems will need the help of a qualified professional. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of these self-help manuals is at an early stage, the work done to date indicates that for a large number of people, such a manual is sufficient for them to overcome their problems without professional help. Sadly, many people suffer on their own for years. Sometimes they feel reluctant to seek help without first making a serious effort to manage on their own. Often they feel too awkward or even ashamed to ask for help. It may be that appropriate help is not forthcoming, despite their best efforts to find it. For many of these people, the cognitive behavioral self-help manual will provide a lifeline to a better future.

Peter J Cooper
The University of Reading, 2009

Preface to the third edition

Bringing compassion to our practice

When Nick Robinson invited me to prepare a third edition of *Overcoming Depression* I was both delighted and daunted. I was delighted because it is over 10 years since the second edition was written and so much has happened in that time in regard to working with depression. I was daunted because I knew there would have to be a fairly substantial rewriting. So, over a year and many five o'clock in the mornings later, here we are.

What is so new that we should get excited? One thing is that the past 10 years has seen a major focus on what is called *mindfulness.* Mindfulness was originally developed within ancient spiritual traditions in the East. Like many other traditions, it proposes that our attention and thoughts contribute to our well-being or distress. It teaches ways to attend to the thoughts and feelings in our minds by becoming more observant and non-judgemental. It also provides various 'exercises' we can practise, which help to balance our state of mind. There is increasing research evidence that this can be extremely helpful to us when we are depressed (and throughout our lives). It is particularly helpful when we tend to avoid our feelings or ruminate on them or judge them to be bad or overwhelming. Chapter 7 is dedicated to this approach.

The second major excitement is the way that our understanding of *compassion* has developed in the past 10 years. We

are learning how we can develop it as a major antidote to depression. There is increasing evidence that training ourselves in compassion and kindness, with regular practice, can actually change our brains. Researchers are now exploring this in detail.

This is exciting, because humans have evolved to be very responsive to kindness. For example, babies don't survive or grow without care and support. If we think about times when we're distressed, it is easy to recognize that the kindness of others helps to soothe us and pull us through. We have also discovered that individuals who are kind and supportive to themselves are also more resilient to life's difficulties than those who are critical and self-condemning. Our brain does not respond very well to self-criticism.

In the preface to the first edition, written 15 years ago, I wrote that 'I see depression as a state of mind that we have a potential for, just as we have a potential to feel grief, fear, sexual arousal and so forth. And like any state of mind, depression is associated with very real changes in the brain.' I went on to say that depression is a brain state and a brain pattern that can affect any of us to differing degrees. Once we know this, then all efforts can be aimed at changing this brain pattern, trying to shift brain states (discussed on my CD *Overcoming Depression*). This is where kindness comes in again, because in Chapter 2 I outline in detail how our emotional systems work to create different patterns and states of mind. I also describe how a combination of mindfulness and compassion can help balance them.

The key message is that there are many ideas to help us when depression grabs hold of our feelings, thoughts and behaviors. We can however learn to act against the desire to withdraw that operates within depression. We can stand back and view our thoughts from the balcony, as it were, and develop a balanced

perspective rather than an overly hostile, critical or pessimistic one. We can learn to develop and seek out helpful and supportive relationships.

Whatever we choose to do to bring more balance to our minds, if we learn to do it with the feelings and intentions of kindness, support and encouragement, recognizing how painful and hard depression is, we are more likely to be successful. When we allow ourselves to feel compassionate – and for some people that is quite a big step – we open ourselves up to being helped and to healing things we may be ashamed of.

Many of the original ideas are still core to this book, but they are now more linked to the importance of compassion for oneself and others, and how to develop it. If you like this approach you may want to pursue it further in other writings, or perhaps further your own explorations into its healing properties.

You will see that as in the previous editions I use a lot of case material. For confidentiality reasons I can only include stories that people have agreed I can use; elsewhere I have combined themes and created fictional characters. To protect confidentiality they are designed to be non-identifiable, and are used primarily to create a narrative that helps the reader's understanding.

I know this a long book but we cover a lot of ground, and you can easily dip in and out of it. Good luck.

Preface to the first edition

Sadly, some people seem at risk of certain types of depression, and we now know that genes appear to play a role. However, while I do not want to underplay the biological dimension of depression, some forms are surprisingly common and genes probably play a major role only in a minority of cases. Life events and early childhood experiences seem by far the more common sources. I suspect this was true for me. My early years were spent in West Africa. It was a place of tremendous freedoms and I would roam happily in the outback. For nearly a year we lived in the 'bush' with no running water or electricity – and no school! My memories are still vivid of that time and when the skies are dull and cold I remember with great fondness the excitements, the blue skies and expansiveness of Africa. When I came home to England to go to boarding school I found the confinement and harshness of it difficult. I also found that I was behind in my education and had serious problems with the English language. To this day I do not like confinements and can easily feel trapped in places. The life events that triggered my depression were all related to feeling trapped and failing.

I see depression as a state of mind that we have a potential for, just as we have the potential to feel grief, fear, sexual arousal and so forth. And like any state of mind, depression is associated

with very real changes in the brain. In my own work I have explored the reasons for this by thinking about the typical things that tend to trigger depression. This led to a consideration of whether the capacity for depression might be something that evolved along with us as we plodded the conflict-ridden trail from reptiles to monkey to humans. I won't go into the details of that except to say that depression probably affects animals. As with humans, depression seems to strike mostly when an animal loses status (is defeated), loses control and/or is trapped in adverse environments. When these things happen the brain seems to switch into depressed-like states. In humans, signals of being valued as a person have evolved as important mediators of mood states.

The other thing to consider, if we stay with an evolutionary view for a moment, is that although the brain is a highly complex organ it is also something of a 'contraption'. Deep in our brains are structures that evolved with the reptiles. Neuropsychologists even called this part of the brain 'the reptilian brain'. Evolution does not create totally new designs. Rather, old designs are adapted, added to or altered as a species evolves. It is rather like developing a car, but each new design must include the old – you can't go back to the drawing board and start afresh. So the brain has various structures within it that stretch way back many millions of years. This is why we can see the brain as a cobbling together of different bits that do different things. We have the potential for great violence, terror, lust, love and compassion. We are a mosaic of possibilities arising out of this jerry-built brain of ours.

Provided these various parts of the brain work together then it functions reasonably well, but if they get out of balance then it functions less well. Due perhaps to childhood trauma or difficulties and later stressful life events, we sometimes find it difficult

to keep this mixed array of possibilities under control. They start pulling in different directions. The brain may tell us that there is far more danger than there is, and we panic; it may tell us that we are inferior, worthless and to give in, and we feel depressed; it may tell us that we need to get our own back, and so we seethe with the desire for revenge. Each of these parts has its own job to do, but they must work in harmony. In depression we lose this harmony and have thoughts and ideas that lead us to feel more defeated, inferior and worthless, and thus more depressed.

What we find in depression is that people experience all kinds of thoughts and feelings coming from different systems within the brain, and these can be difficult to control or make sense of. Another way to think of this is that we have different parts to ourselves and can play different roles, e.g. child, hero, lover, parent, friend, enemy, helper and so on. Evolution has provided many brain systems that enable us to enact different roles. Each part tends to see the world in its own way. For example, the hero part strides out and risks all. The coward part says, 'You must be joking. I'm not going out there.' Now if the two work together then they will make a sensible compromise and evaluation of risk. But if the hero does not listen to the coward then the hero puts the self in danger. On the other hand, if the coward does not listen to the hero, the coward just hides in the corner. In reality, of course, there are no actual 'parts' as such; what we experience is the activation, to a greater or lesser degree, of different brain systems. When we pay attention to our thoughts and feelings we can actually recognize which brain systems are turned on. Our thoughts and feelings are windows on these different systems in us.

So what to do if you feel depressed? The first thing to say is that the thoughts we have when we are depressed tell us that

the depression system is switched on. That may not seem very helpful, until we realize that there may be ways to turn it off again and bring ourselves back into balance. For example, when we are depressed we may think in ways that seem right 'to the depression', but which may seem very wrong to other parts of ourselves. The rational and compassionate parts of ourselves may have a very different view of things. The more we can say, 'OK, my depression is a part of me; one of my many brain systems, but it can't be relied on to be accurate or helpful', the more we can step in to try to take control of it.

Second, as we get depressed the depression system tends to throw other systems out of balance. For example, we may become more irritable or anxious. And as a result we may judge ourselves and/or others more harshly, which feeds the depression. Typical of depression is to devalue things, usually ourselves and accomplishments, but we may also devalue others. We may start to believe that things are darker than they are.

Third, depression is about how the brain is operating at any particular time. So depression is very much felt 'in the body' and is about feelings. Depression was designed (evolved) to slow us down, to weaken self-confidence and make us more sensitive to possible social losses and threats. It does this by changing the way our bodies work. However, if we can get other systems to challenge the depression, by learning how to think differently about ourselves and events, then we have an opportunity to get things back into balance. This book will discuss how to recognize important depressing thoughts to work with and how to challenge them.

This book is for people who would like to know more about depression – what it is and how to help oneself. It is not a cure-all, nor a substitute for therapies like drugs or psychotherapy, nor can a book like this change the painful realities of living.

It is simply one approach. Each person's depression is, in part, similar to other people's and in part unique to that person. What understanding can do is to offer a way to move out of depression rather than plunge further into it. There are many ways to challenge some of the negative thinking of depression. I will try to point out some pitfalls to watch out for and suggest some methods that will enable you to develop a more rational and compassionate approach to yourself.

The book is divided into three parts. The first is the most technical. I have included this because many of the depressed people I see say that they would like to know more about depression itself. If it seems too technical, you can skip those bits you find difficult to follow; in fact, you can skip the whole of Part I if you like. Part II outlines some basic approaches to self-help. Here we will explore the role of thoughts and feelings, and how to challenge some of the thoughts and feelings that lead to a downward slide. There is a chapter devoted to how depressed people treat themselves (which is often very badly) and how to treat yourself more kindly. The more you learn to value yourself (or at least to stop devaluing yourself), the greater the chances of turning the depression system off. Each chapter in Part II is followed by a series of exercises you can try. In Part III the basic approaches covered in Part II are applied to special problems. These include the need for approval, anger, shame, lack of assertiveness, disappointment and perfectionism.

You will read of many other people's depression. All names have, of course, been changed. Also, to avoid any chance of identification, the details of all the stories have been altered. Sometimes two or three cases have been rolled into one, again to avoid identification. The focus of each problem is on the specific themes that reveal the dilemmas and complexities of depression.

Our journey together may be a long one, but I hope it will equip you with some ideas of how to move out of depression. Recovering from depression usually requires time, effort and patience, but if you know what you are trying to achieve, and have a way forward, you are likely to be more successful in your efforts. So let's begin.

PART ONE
Understanding Depression

1

What is depression?

If you suffer from depression, you are, sadly, far from being alone. In fact, it has been estimated that there may be over 350 million people in the world today who have it. Depression has afflicted humans for as long as records have been kept. Indeed, it was first named as a condition about 2,400 years ago by the famous ancient Greek doctor Hippocrates, who called it 'melancholia'. It is also worth noting that although we cannot ask animals how they feel, it is likely that they also have the capacity to feel depressed: they can certainly behave as if they do. To a greater or lesser degree, we all have the potential to become depressed, just as we all have the potential to become anxious, to grieve or to fall in love.

Depression is no respecter of status or fortune. Indeed, many famous people throughout history have had it. King Solomon, Abraham Lincoln, Winston Churchill and the Finnish composer Jean Sibelius are well-known examples from history. What is important to remember is that depression is not about human weakness.

What do we mean by 'depression'?

This is a difficult question to answer, because a lot depends on who you ask. The word itself can be used to describe a type of weather, a fall in the stock market, a hollow in the ground and,

of course, our moods. It comes from the Latin *deprimere*, meaning to 'press down'. The term was first applied to a mood state in the seventeenth century.

If you suffer from depression, one thing you will know is that it is far more than just feeling 'down'. In fact, depression affects not only how we feel, but how we think about things, our energy levels, our concentration, our sleep, even our interest in sex. Depression has an effect on many aspects of our lives. Let's look at some of these.

- **Motivation**. Depression affects our motivation to do things. We can feel apathetic and experience a loss of energy and interest, nothing seems worth doing. If we have children, we can lose interest in them and then feel guilty. Each day can be a struggle of having to force ourselves to perform even the smallest of activities. Some depressed people lose interest in things. Others keep their interest but don't enjoy things when they do them, or are just very tired and lack the energy to do the things they would like to do.
- **Emotions**. People often think that depression is only about low mood or feeling fed-up – and this is certainly part of it. Indeed, the central symptom of depression is called 'anhedonia'– derived from the ancient Greek meaning 'without pleasure'– and means the **loss of the capacity to experience any pleasure**. Life seems empty; we are joyless. But – and this is an important 'but' – although the ability to have positive feelings and emotions is reduced, we can experience an increase in negative emotions, especially anger. We may be churning inside with anger and resentment that we can't express. We might become extremely irritable, snap at our

children and relatives and sometimes even lash out at them. We may then feel guilty about this, and this makes us more depressed. Other very common symptoms are anxiety and fear. When we are depressed, we can feel extremely vulnerable. Things that we may have done easily before seem frightening, and at times it is difficult to know why. We can suddenly feel anxious at a bus or shop queue or even meeting friends. Anger and anxiety are very much part of depression. Other negative feelings that can increase in depression are sadness, guilt, shame, envy and jealousy.

- **Thinking**. Depression interferes with the way we think in two ways. First, it affects concentration and memory. We find that we can't get our minds to settle on anything. Reading a book or watching television becomes impossible. We don't remember things too well, and we are prone to forget things. However, it is easier to remember negative things than positive things. The second way that depression affects our thoughts is **in the way we think** about ourselves, our future and the world. Very few people who are depressed feel good about themselves. Generally, they tend to see themselves as inferior, flawed, bad or worthless. If you ask a depressed person about their future, they are likely to respond with: 'What future?' The future seems dark, a blank or a never-ending cycle of defeat and losses. Like many strong emotions, depression pushes us to more extreme forms of thinking. Our thoughts become 'all or nothing' – we are either a complete success or an abject failure.
- **Images**. When we are depressed, the imagery we use to describe it tends to be dark. We may talk about being

under a dark cloud, in a deep hole or pit, or a dark room. Winston Churchill called his depression his 'black dog'. The imagery of depression is always about darkness, being stuck somewhere and not able to get out. If you were to paint a picture of your depression, it would probably involve dark or harsh colours rather than light, soft ones. Darkness and entrapment are key internal images.

- **Behaviors**. Our behavior changes when we become depressed. We engage in much less positive activity and may withdraw socially and want to hide away. Many of the things we might have enjoyed doing before becoming depressed now seem like an ordeal. Because everything seems to take so much effort, we do much less than we used to. Our behavior towards other people can change, too. We tend to do fewer positive things with others and are more likely to find ourselves in conflict with them. If we become very anxious, we might also start to avoid meeting people or lose our social confidence. Depressed people sometimes become agitated and find it difficult to relax. They feel like trapped animals, restless, pace about and can't sit still, wanting to do something but not knowing what. Sometimes, the desire to escape and run away can be very strong. However, where to go and what to do is unclear. On the other hand, some depressed people become very slowed down. They walk slowly, with a stoop, their thoughts seem stuck, and everything feels 'heavy'.
- **Physiology**. When we are depressed there are many changes in our bodies and brains. There is nothing sinister about this. To say that our brains work differently when we are depressed is really to state the obvious. Indeed, any mental state, be it a happy, sexual, excited,

anxious or depressed one, will be associated with physical changes in our brains. Recent research has shown that some of these are related to stress hormones such as cortisol, which indicates that depression involves the body's stress system. Certain brain chemicals, called neurotransmitters, are also affected. Generally, there are fewer of these chemicals in the brain when we are depressed, and this is why some people find benefit from drugs that allow them to build up. The next chapters will explore these more fully. Probably as a result of the physical changes that occur in depression, we can experience a host of other unwanted symptoms. Not only are energy levels affected, so is sleep. You may wake up early, sometimes in the middle of the night or early morning, or you may find it difficult to get to sleep, although some depressed people sleep more. In addition, losing your appetite is quite common and food may start to taste like cardboard, so some depressed people lose weight. Others may eat more and put on weight.

- **Social relationships**. Even though we may try to hide our depression, it almost always affects other people. We are less fun to be with. We can be irritable and find ourselves continually saying no. The key thing here is that this is quite common and has been since humans first felt depressed. We need to acknowledge these feelings and not feel ashamed about them. Feeling ashamed can make us more depressed. There are various reasons why our relationships might suffer. There may be conflicts that we feel unable to sort out. There may be unvoiced resentments. We may feel out of control. Our friends and partners may not understand what has happened to us. Remember the old saying, 'Laugh and the world laughs

with you. Cry and you cry alone'? Depression is difficult for others to comprehend at times.

- **Brain states**. A useful way to think of depression, then, is that it is a change in 'brain states'. In this altered state, many thing are happening to your energy levels, feelings, thoughts and body rhythms. There are many reasons for this change in brain state that we call depression, and there are many different patterns that are linked to depression, as we will see. But the key thing is to recognize there has been a change in brain state, and your thoughts and feelings are linked to that. It is very important **not to blame yourself** for the difficulties that this depressed brain state makes for you, but rather **work out what will help you shift it** – and that is what we will be exploring in this book.

Are all depressions the same?

The short answer to this is no. There are a number of different types. One that researchers and professionals commonly refer to is called 'major depression'. According to the American Psychiatric Association, one can be said to have major depression if one has at least five of the possible symptoms listed in Table 1.1, which have to be present for at least two weeks.

I have included this list of symptoms here to give you an idea of how some professionals tend to think about depression. Although a list like the one in Table 1.1 is important to professionals, it does not really capture the variety and complexity of the experience of depression. For example, I would include feelings of being trapped as a common depressed symptom, and many psychologists feel that hopelessness, irritability, and anxiety are also very central to depression.

TABLE 1.1 SYMPTOMS OF DEPRESSION

You must have one of these symptoms:	Low mood Marked loss of pleasure
You must have at least four of of these symptoms:	Significant change in appetite and a loss of at least 5 per cent normal body weight Sleep disturbance Agitation or feelings of being slowed down Loss of energy or feeling fatigued virtually every day Feelings of worthlessness, low self-esteem, tendency to feel guilty Loss of the ability to concentrate Thoughts of death and suicide

Researchers distinguish between those mental conditions that involve only depression and those that also involve swings into mania. In the manic state, a person can feel enormously energetic, confident and full of their own self-importance, and may have great interest in sex. If the mania is not too severe, they can accomplish a lot. People who have swings into depression and (hypo)mania are often diagnosed as suffering from *bipolar illness* (meaning that they can swing to both poles of mood, high and low). The old term was manic depression. Those who only suffer depression are diagnosed as having *unipolar depression*.

Another distinction that some researchers and professionals make is between *psychotic* and *neurotic* depression. In psychotic depression, the person has various false beliefs called *delusions*. For example, a person without any physical illness might come to believe that he or she has a serious cancer and will shortly die. Some years ago, one of my patients was admitted to hospital because she had been contacting lawyers and undertakers to arrange her will and her funeral as she was sure that she would die before Christmas. She believed that the hospital staff were keeping this important information from her to avoid upsetting

her, and she tried to advise her young children on how they should cope without her (causing great distress to the family, of course). Sometimes people with a psychotic illness can develop extreme feelings of guilt. For example, they may be certain in their minds they have caused the Iraq war, or done something terrible. Psychotic depression is obviously a very serious disorder, requiring expert help but, compared with the non-psychotic depressions, it is quite rare.

Another distinction that is sometimes made is between those depressions that seem to come out of the blue and those that are related to life events, e.g., when people become depressed after losing a job, the death of a loved one or the ending of an important relationship. However, in psychotherapy, we often find that, as we get to know a person in depth, what looks like a depression that came out of the blue actually may have its seeds in childhood.

Clearly some depressions are more serious, deep and debilitating than others. In many cases, depressed people manage to keep going until the depression eventually passes. In more serious depression this is extremely difficult, and getting professional help is important. Depressions can vary in terms of onset, severity, duration and frequency.

- **Onset**. Depression can have an acute onset (i.e. within days or weeks) or come on gradually (over months or years). It can begin at any time, but late adolescence, early adulthood and later life are particularly vulnerable times.
- **Severity**. Symptoms may be mild, moderate or severe.
- **Duration**. Some people will come out of their depression within weeks or months, whereas for others it may last in a fluctuating, chronic form for many years. 'Chronic

depression' is said to last longer than two years, and 10–20 per cent of depressed people have it.

- **Frequency**. Some people may only have one episode of depression, whereas others may have many. About 50 per cent of people who have been depressed will have a recurrence.

The fact that depression can recur may seem alarming, but this should really come as no surprise. Suppose, for example, that since a young age you have always felt inferior and worthless. One day this sense of inferiority seems to get the better of you and you feel a complete failure in every aspect of your life. Perhaps a drug will help you to recover from that episode, but even if you become better, you may still retain, deep down, those feelings of failure and inferiority. Drugs do not retrain us or enable us to mature and throw off these underlying beliefs. Therapies are now being developed to help prevent relapses.

How common is depression?

As indicated, depression is, sadly, very common. If we look at what is called major depression, the figures are:

	Women	*Men*
	(per cent)	
Having depression at any one time	4–10	2–3.5
Lifetime risk	10–26	5–12

The figures are even higher in some communities (e.g., with poverty). Moreover problems such as eating disorders, drug and alcohol problems and aggressiveness can also be linked to depression, and recede as depression is treated. New research also

indicates that rates of and risks for depression have been steadily increasing throughout the twentieth century, but the reasons for this are unclear. Socio-economic changes, the fragmentation of families and communities, the loss of hope in the younger generation – especially the unemployed – and increasing levels of expectations may all be implicated.

In general, then, there are many forms of depression – in fact, so many that the term itself is not so helpful. But it is important to recognize that not all depressions are the same and they can vary greatly in severity and duration.

KEY POINTS

- Depression is very common and has been for thousands of years.
- Depression involves many different symptoms. Emotions such as anger and anxiety are common and at times more troubling than the low mood itself. People who are depressed may also have a strong desire to escape, for which they may feel guilty.
- There are many different types of depression.
- Some depressions are quite severe, while others are less so but still deeply disturbing and life-crippling.

If you suffer from depression, my key message to you is that if you feel a failure, if you have a lot of anger inside, feel on a short fuse; if you are terrified out of your wits, if you think life is not worth living, if you feel trapped and desperate to escape – whatever your feelings – these reflect your brain state, are not your fault, and millions of others have these feelings too. Of course, knowing this does not make your depression any less painful, but it does mean that there is **nothing bad about you because you are in this state of mind**. It is a shift in brain state that is painful – depression pulls us into thinking and feeling like this, so these feelings are sadly part of being depressed. True, some

people who have not been depressed may not understand it, or may tell you to pull yourself together, but this does not mean that there is anything bad about you. It just means that they find it difficult to understand.

Importantly, there are many things that can be done to help us when we get depressed so a key message is: 'please talk to your family doctor.' There are some helpful (for some people) drugs (anti-depressants) available and many effective psychological treatments. We can learn to train our minds to shift us out of depressed brain states. This is covered in Parts II and III.