Dealing with Major Depression; Managing Malignant Sadness

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(Stand-by talk to be given to . . . on 2013.)

This evening's talk is an expanded version of an address I gave in January 2013 to the Melbourne Unitarian Church; and that in turn was based on an article I first wrote in 2003. What I am offering now is mainly a personal account of clinical or major depression, also called major depressive disorder, recurrent depressive disorder, unipolar depression and unipolar disorder.

I must stress that I am not talking about reasonable degrees of grief, low morale and sadness, which affect almost everyone from time to time, but an intrusive and often disabling mood disorder: severe melancholia, often accompanied by anxiety, fatigue or agitation, despair, feeling overwhelmed or helpless, social withdrawal or finding the company of others difficult, inability to enjoy life, increased sleep or else premature waking, and either loss of appetite or increased desire for food and comfort. The sufferer may also wish he or she were dead. Professor Lewis Wolpert has called it, very appropriately in my opinion, malignant sadness.

According to Wikipedia, "the lifetime risk of suicide" associated with a diagnosis of major depression in the United States is estimated at 3.4 per cent. What is interesting here is that the 3.4 per cent is made up of almost 7 per cent for men and only 1 per cent for women, although women are more likely to attempt suicide — unsuccessfuly. Also, in most First World countries, women are more likely to seek help for depression than men. In Australia there are roughly 23 million human beings, and today 4.1 per cent of them, or about 940,000 people, are suffering from a depressive disorder.

I do not intend to talk about manic depression, also termed bipolar disorder, as I know very little about it. Indeed, I am not sure I have knowingly talked to anyone who has suffered from it.

Bear in mind also, please, that I am not a health professional and my knowledge of depression is unlikely to be up to date.

I was first diagnosed with depression in 1962, at the age of 18, but I was often deeply unhappy and maybe depressed at times during the previous ten years. I have had to endure depression, for varying lengths of time, for fifty years; and it has wrecked my more important ambitions, hopes and plans. You could say that it is a short straw I have drawn in the lottery of life.

Causes

The exact mechanism or cause of depression is open to dispute, and some writers claim it is unknown or unknowable. “As I see it it,” wrote Professor David Karp in 1996, “efforts to authoritatively uncover the causes of depression are doomed to failure.”[1] William Styron, writing a few years earlier, said:

> “I shall never learn what ‘caused’ my depression, as no one will ever learn about their own. To be able to do so will likely forever prove to be an impossibility, so complex are the intermingled factors of abnormal chemistry, behavior and genetics.”[2]

Some people assume that severe depression, especially if recurrent, is a sign of an abusive or dysfunctional childhood. In reality, life is not as simple as that. People who have had unhappy childhoods, and I am certainly one, are more prone to depression and other problems, but they do not all suffer from depression by any means. Professor Raymond Cochrane, speaking in 1995, said that “Victims of child abuse are at least twice as likely to suffer clinical depression in adulthood as non-victims”, and he added: “Up to 70% of depressed patients admitted to hospitals have been abused as children.”[3]

On the other hand some people who have had normal or happy childhoods may become depressed. The Huxley family does not seem to have been dysfunctional or abusive, but Thomas Henry Huxley suffered from depression, as did his grandson Sir Julian Huxley. One of Julian’s brothers was a depressive, and committed suicide; and one of T. H. Huxley’s daughters, if I remember correctly, had severe post-partum depression.

I share the view that clinical depression seems to be a mixture of genetics and experience. In other words, people with a genetic predisposition react to significant events, such as stress, by becoming depressed, whereas others would become angry, anxious, tired or would be adaptable enough to cope. And enough stress, such as being tortured or held hostage for a long time, will often trigger depression in all but the most robust of people. I have come across the suggestion that the genetic element may work in two ways: in favourable or encouraging circumstances it might make the person with the trait more creative or socially skilled; but in adverse conditions the trait may lead to depression.

One theory is that in depressives the two small, almond-like bodies in the brain, the amygdalae, instruct the adrenal glands to produce too much of the stress hormone cortisol. This prevents each hippocampus of the brain from producing enough neurotransmitters called monoamines, such as dopamine, epinephrine, norepinephrine, melatonin and serotonin, and this unbalanced

mix of too much cortisol and not enough monoamines interferes with nerve development and connexions in the hippocampi and frontal lobes, and may stop or retard the formation of new nerve cells, giving rise to depressive symptoms. Some depressives have indeed been found to have brains with enlarged amygdalae and smaller than normal hippocampi.[4]

The theory offers an explanation of why, when they work, antidepressant drugs usually take ten to twenty days to show any benefit, because they are thought to permit the growth of new nerve cells and nerve connexions. With time the theory may need revising or even discarding, but it seems more plausible than dubious claims that depression has, for some mysterious reason, a cause that is unfathomable or unknowable.

There might also be an epigenetic link to depression. Epigenetics refers to the way in which environmental factors effect not what a gene is coded to do, but whether it is activated or not and to what extent it is expressed. It is a bit like an on-off and volume control. I do not want to bog you down with definitions, so I will give you an example. If after three days honey bee larvae are fed on pollen and nectar, they develop into worker bees; and if the larvae are fed on royal jelly, they develop into queens. But the workers and queens have essentially the same genetic code.

In a talk[5] in October 2012 to South Place Ethical Society, London, Dr Nessa Carey, author of *The Epigenetics Revolution* (2011), explained that if baby rats get a lot of licking and grooming from their mothers, the young grow up into "chilled-out adults who aren't that bothered by mildly stressful stimuli". She added: "But if the babies are raised by females who are stingy with the licking and grooming, they grow up into highly stressed individuals, reacting disproportionately in response to mild stimuli."

The brains of the adult rats were found to differ significantly, as Dr Carey explained: "Certain key genes which encoded proteins involved in the fight-or-flight response to stress were expressed differently, depending on the upbringing of the rat. Specifically, the 'unloved' babies expressed the fight-or-flight genes more highly as adults than the animals who had been nurtured. Essentially, their baseline background stress levels were much higher than normal."

According to Nessa Carey, "These differences in gene expression . . . had nothing to do with the genetic code. This was identical in both experimental groups. They were caused by differences in small chemical modifications to the DNA of the relevant genes. These are known as epigenetic modifications and they don't change what the genes code for. Instead, they influence how highly genes are switched on . . . In the neglected rats, these modifications to the

brain cells were established early in life when the rat baby was having a really stressful time. But then the modifications got stuck, and the animals' brains were locked into a particular pattern of gene expression even when they were adults."

So there may be an epigenetic explanation of at least some forms of chronic depression.

And I think William Styron showed insight into many, though I suspect not all, instances of depression when he wrote: "Much obviously remains to be learned . . . but . . . one psychological element has been established beyond reasonable doubt, and that is the concept of loss. Loss in all of its manifestations is the touchstone of depression — in the progress of the disease and, most likely, in its origin."[6]

The American psychoanalyst Erik Erikson attributed to Sigmund Freud the saying that what was needed for emotional health was *Arbeiten und Lieben*, to work and to love, but implying satisfying work or creative interests and sustaining intimate ties of various sorts. I think the concept of work and creativity combined with connectedness in various forms, with adequate time and opportunity for both, is profoundly important.

Depression & religion here

I have come across occasional references to a link between depression and heart disease, though the connexion may be indirect rather than direct. Depression is often thought to be triggered by stress, and depression itself is very stressful. Also some depressives appear to have had childhoods that were more stressful than normal. Chronic stress is also given as a factor in heart disease. Whatever the nature of the link between depression and heart disease, this is grounds for not neglecting depression.

We do not know for certain whether major depression is a single mood disorder or a group or cluster of disorders with similar symptoms. Back in the 1960s people used to talk of reactive depression, where there seemed to be an obvious cause or trigger, and endogenous depression, where someone became deeply depressed for no obvious reason. I have always been wary of these classifications, as causes or triggers might not be what they seem; and depression may require a combination of factors to appear.

However, I think we can be comfortable about the condition known as seasonal affective disorder (or SAD), where someone characteristically become depressed or almost so during the winter months. This does seem to be connected with day length, though again there may be an element of genetic predisposition.

There is also post-partum or postnatal depression in women. This may well

be set off by changes in hormone levels after giving birth, but I would not rule out a genetic component as well.

I am happier with the symptom classifications of typical and atypical depression because I have personal experience of them. Depression with typical symptoms includes melancholia, anxiety, helplessness, premature waking in the morning and reduced appetite for food. Atypical symptoms include wanting more sleep and not usually waking earlier than normal, and, in particular, increased desire for food and sometimes a craving for sweet foods.

I always had atypical symptoms when I was depressed from 1962 to 2007, and the food craving was very marked. I would sometimes put on a lot of weight, and do my best to lose weight when feeling a bit better. In late 2008, however, I was surprised to find I had typical symptoms. I would wake up too early, my desire for food was reduced, and there was a greater anxiety component. I cannot explain the sudden and permanent change, and can only assume it had something to do with ageing.

Treatment

From time to time I have heard journalists and doctors announce: "The good news about depression is that it is treatable." *Everything* is treatable, even terminal illness and death; but what matters is whether treatment is effective. By effective I mean clearly causing major improvement that is either long lasting or permanent.

What is rarely mentioned is that between six and fifteen per cent of depressives do not respond effectively to known methods of treatment. I am a very hard-to-treat depressive, but I am not impossible to help. My misfortune, however, was that treatments available in the 1960s and '70s failed to help me or made things worse.

Drug therapy

Writers and speakers on depression often claim that a specific antidepressant drug will help about 60 per cent of patients, and that certain types of psychotherapy, particularly cognitive behavioural therapy, will also have about the same rate of effectiveness.

Antidepressant drugs have helped and can help very many people, but drugs may also do harm. I went without treatment for years because of doctors who doled out tricyclic antidepressants to me. Tricyclics were the first class of antidepressants to be widely used.[7] The worst hell I know is severe depression compounded by the sedation caused by tricyclic drugs. Other

antidepressants can cause anxiety, impaired balance, sexual malfunctioning and raised blood pressure. But of course this does not mean that antidepressant drugs are not worth trying.

I first saw a psychiatrist in 1962, but the first time any treatment really helped me was in 1996, when I asked to try a particular drug because it had a side-effect profile I reckoned I could tolerate. I did not expect it to work but, to my very considerable surprise, after just over a week it raised my mood, but only for about six weeks, and then packed up rapidly. A second medication worked for about as long, but not nearly as well, and eventually did not work at all. Later on I found two more drugs[8] that were as good as the first, and lasted longer, but after a few months they too packed up or "dropped out", but not for good. When a drug "dropped out", if I stayed off it for about six months, there was a good chance it would work again, but not permanently, of course.

Psychotherapy

Most mental health professionals regard a limited range of psychotherapies as being beneficial for at least mild or moderate depression.

Over the years I have tried group psychotherapy, Freudian psychoanalysis, Jungian psychoanalysis — briefly, hypnotherapy — twice, and forms of cognitive therapy — twice. Experience of psychoanalysis changed me from true believer to convinced sceptic.

From all these forms of therapy I discovered little that was new or of value about my emotions, except and maybe importantly, that I was not paranoid or deluded, and could trust my memory and judgement. But I learned a fair amount about the thinking and preconceptions of psychotherapists. Yes, I was probably very introspective by temperament, but in some instances I was surprised by the therapist's lack of empathy and insight.

A psychologist I saw in 1999 asked me to write down how I hoped my life might differ if I were no longer depressed. I produced a detailed and careful list. The therapist looked briefly at the list and remarked "It would have been better if, instead of writing 'If I were not depressed I would', you had written 'When I am not depressed I will'."

I realised that this man put a low value on truthfulness; and the more I got to know him, the less trustworthy I found him. He tended to duck issues that mattered to me by saying they were unimportant and refusing to discuss them. He was full of easy slogans and facile promises that lacked substance: his methods were "all gong, no dinner"! I got worse towards the end of the sessions, and worse still after I stopped seeing him.

Electroconvulsive therapy

Electroconvulsive therapy (E.C.T.) rarely gets a mention nowadays. This is probably because it was overused, misused and grossly abused in the past for treating depression and a number of other illnesses. It is now used very sparingly, under careful supervision, for certain types of drug-resistant depression, especially catatonic depression, and a qualified anaesthetist has to be present. It does work on some chronic and severe depressives, and can make a great difference to their quality of life.

I tried a course of E.C.T. in 2002. It did not reduce my depression, and it caused short-term memory loss and periods of anxiety. The memory loss was sometimes rather farcical, occasionally a bit scary. However, I am glad I was given the chance to try E.C.T.

Exercise and alcohol

Exercise is often recommended as good for depression. In my case, however, it nearly always had the opposite effect: it increased suicidal feelings, often markedly, because when exercising I could not normally occupy my mind. The things that help me, when very depressed, are, besides emotional support, writing, reading, or watching something engrossing on television. These are partial anodynes or escapes and, of course, as soon as I stop doing them I am fully aware again of the depression.

In late 2004 a friend told me that, while listening to the radio, she had heard a report about recent research on exercise and depression. The gist of the report was that, although regular exercise could be beneficial for people with mild depression, exercise was often useless or counterproductive in cases of major depression. This seems to corroborate my experience that exercise made me feel worse, or even much worse, when I was depressed. In fact wanting exercise or being able to enjoy it was a reliable sign that my depression levels had become very low, but I now have osteoarthritis in my right knee, so I cannot walk very much, which, when otherwise well, I find frustrating.

Mental health professionals regularly warn against the use of alcohol as a form of self-medication for depression. Alcohol may give brief and partial relief from depression, but it certainly does not “fix” depression; and I am sure that alcohol abuse will exacerbate any mood disorder or mental illness. I am aware of the risks of using alcohol too freely, and I decided when I started driving regularly, in 1981, not to drink alcohol earlier than 5:30 p.m., even on Christmas Day.

If my memory is reliable I can think of perhaps a couple of occasions when

moderate alcohol use might have stopped me attempting suicide, by making me relaxed and sleepy, and dampening down suicidal thoughts. However, I suspect alcohol may well have the opposite effect on some people with depression.

If I have learned nothing else in the last fifty years, it is that what helps one person with depression may be useless or downright harmful for someone else.

I have also learnt that congenial work or creative activity usually correlates with low levels of depression, and unemployment and uncongenial work are linked with high levels of depression. But depression has, of course, markedly limited my employment prospects, so I have at times been in something of a vicious circle.

Even as a young man I realised that, unless I could get my depression really under control, my life would be wrecked. So I spent a lot of time, money and effort both on treatment and self-help measures, like major changes of lifestyle, but the results were often rather poor.

Bad experiences . . .

I have been unimpressed with a significant minority of mental health professionals I have encountered over the years. One psychiatrist in 1966 kept me waiting for seven months for group psychotherapy, despite my saying I doubted if it would work because I would feel inhibited in a group. Another psychiatrist told me I did not look very depressed as I was wearing my best suit. (I had some cousins' party to attend afterwards, but I had been feeling suicidal for months.) A third psychiatrist decided I had "existential" depression.

I have a report (1997) on file by a young psychiatric nurse who wrote that she did not believe I was suffering from a depressive illness and "it is not surprising that antidepressant therapy has had minimal to nil positive effect on him to date". The next year (1998) I was referred to an eminent specialist psychiatrist in Melbourne who diagnosed that I had moderate to severe chronic major depression.

In 1996 a doctor at a Victorian regional psychiatric hospital gave me a very narrow and grossly misleading definition of depression in order, I presume, to convince me I was not "really" depressed. The chief nurse at the same hospital told me how little regard he had for most of the patients because he believed they had made themselves psychotic through excessive use of cannabis. This fellow had probably not stopped to ask himself *why* people might abuse cannabis to this extent. (I have never been psychotic and I have never used

cannabis.)

In 2010 I had the misfortune to be referred to a psychiatrist who spent more than twenty minutes of the eighty-minute consultation in a digression on modern art. At times I felt he was barely listening to me. This was borne out by the report sent to my G.P., whom I had already warned. The report said that "On interview today, he was a long haired, articulate man, who appeared intelligent. . . . Unfortunately, he has intellectualised his medical treatment over the years and has developed a belief that changing his anti-depressant every six months has kept him well." I had said nothing of the kind, of course.

The report then stated: "He is convinced that he will be requiring a change in anti-depressants soon and feels that moclobemide would be the safest option." Er, no. I had been referred to the psychiatrist because the three antidepressants my G.P. and I had been able to rely on in the past, including moclobemide, were no longer helping me, and I had said so.

On the other hand I have been impressed with books on depression by people who suffer from it, particularly Professor David Karp's *Speaking of Sadness* (1996), William Styron's *Darkness Visible* (1991) and Lewis Wolpert's *Malignant Sadness: the anatomy of depression* (London, 1999). Professor Karp discovered that people with chronic depression in the United States did not usually get better: they went from professional to professional, looking for "the right one", and finally – gave up! I have probably learnt as much about depression from writers who have suffered from it as from people who claim they can fix it.

I would like to quote a few words from William Styron: "Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self — to the mediating intellect — as to verge close to being beyond description. It thus remains nearly incomprehensible to those who have not experienced it in its extreme mode . . ."[9]

Elsewhere in the book Styron says: "The most honest authorities face up square to the fact that serious depression is not readily treatable. . . . Those that do claim an easy way out are glib and most likely fraudulent."[10]

Not all writers about depression are kind about it. The best example of what I mean comes from a book published in 1975, *The Denial of Death,* by Ernest Becker, who clearly thought depressives were a gutless lot:

> "Adler . . . revealed how perfectly depression or melancholia is a problem of courage; how it develops in people who are afraid of life, who have given up any semblance of independent development and have been totally immersed in the acts and the aid of others. They have lived lives of 'systematic self-restriction,' and the result is that the less you do the less you can do, the

> more helpless and dependent you become. . . . If one's life has been a series of "silent retreats," one ends up firmly wedged into a corner and has nowhere else to retreat. This state is the bogging-down of depression. Fear of life leads to excessive fear of death. . . . Finally, one doesn't dare to move – the patient lies in bed for days on end, not eating, letting the housework pile up, fouling the bed.
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> "The moral of this example of failure of courage is that in some way one must pay with life and consent daily to die, to give oneself up to the risks and dangers of the world, allow oneself to be engulfed and used up. Otherwise one ends up *as though dead* in trying to avoid life and death. This is how modern existentialist psychiatrists understand depression, exactly as Adler did at the beginning of this century."[11]

This strikes me as contempt masquerading as psychology. And since when did depressives in general have an "excessive fear of death"? I suggest we all give "existential" psychiatrists a very wide berth!

In 2003, with the help and encouragement of my then psychiatrist and later friend, Dr Philip Wood, I wrote an article, "Existing with Depression". I submitted it to *The Skeptic*, magazine of the Australian Skeptics, and it was published in December 2003. A year later I added to it in the form of a published letter. The text of the article and letter, with a few additions, formed my contribution to Chapter 7 of Maria Prendergast's book, *Understanding Depression*, published by Penguin Australia in 2006.

When "Existing with Depression" first appeared in print, I imagined it would attract a bit of comment and very probably adverse criticism. To my surprise, e-mail messages kept coming in to me about it for more than a year. I received several times more feedback about this one article than about everything else of mine ever published put together. I was particularly astonished that all the comments on the article were complimentary.

Finally, what can I say to other people with depression? First, beware of those who talk about "beating", "conquering" or "curing" depression. You may be fortunate in having a single bout of depression from which you make a complete and lasting recovery; but for many sufferers depression recurs or, in varying degrees, persists. It can quickly turn living into mere burdensome existence, as can arthritis, a medical condition by analogy with which depression has been compared by some writers. So seek methods to lighten the burden. You may or may not be able to shed the burden entirely, but living with a lightened burden is better than a burdensome existence.

I know what it is like to feel suicidal for years on end. I also know how it felt to try – unsuccessfully – to prevent someone I cared about, my maternal grandmother, from committing suicide. Yes, you have the right to commit

suicide, but doing so without trying a range of treatments for depression is a needless waste of your life. Treatment may help not only you; it may indirectly help others, such as the people you live with or other depressives. Even if you cannot reduce your depression below intolerable levels, remember that clumsy attempts at suicide can make things very much worse. If you jump off a building, you may still be alive at the bottom – but in a wheelchair for the rest of your life.

Seek help from professionals who are trustworthy. Professionals who give you just the "good" news, who lie to you, or who persist in treatments that are endlessly drawn out, without any benefit, or that make you worse, are not worth bothering with. If your psychiatrist or psychologist behaves like a bombastic creep, trust your own judgement — yes, this is sometimes very hard when you are miserable, withdrawn and desperate — and try to find someone else who is better!

Remember that even the best professionals are fallible. A good psychiatrist may try you on a drug that makes you worse simply because it is often hard to predict reliably how a drug will affect you. If the side effects are unbearable or clearly dangerous, and you are often the best judge of this, stop taking the medication. If they are unpleasant but bearable, put up with the drug for a reasonable period and, if things do not improve, ask for the drug to be changed or stopped. A good professional will accept this; a bad one will say you have not tried long enough, or that the drug or treatment helps "everybody".

If you get the chance, talk to other people who have – or have had – depression. They may help you put your own problems into perspective, and they may be able to give you helpful advice. Remember, however, that what is right for someone else may not be appropriate for you.

If you find you have recurrent depression, make sure you keep your own permanent and accurate record of treatments and their effects on you.

Finally, beware of the notion that you deserve to be depressed: that you must have done something wrong to be depressed, or that depression is some sort of cosmic punishment. Never trust anyone who says, "Oh, snap out of it!" or "It's all your own fault!". *Nobody volunteers for depression*, nor are people depressed because they are in some way unworthy of happiness. Look around, and you will occasionally find on the one hand cruel, greedy scoundrels who seem to live happy, prosperous lives without a moment of depression, and on the other hand good, kind, generous people whose lives are blighted by bereavement, disability, disease or early death.

In the real world horrible and unfair things happen to good people. Having

depression is a grave misfortune but, once you realise you are depressed, you do not have to be fatalistic and do nothing about seeking help.

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1 KARP, David A., 1996; *Speaking of Sadness; depression, disconnection and the meaning of illness* (New York): 14.

2 STYRON, William, 1991, *Darkness Visible*: *a memoir of madness* (London): 38.

3 COCHRANE, 1995, "Women and Madness"; *Ethical Record* (London), *100* (6), June: 12 – 17.

4 FARLEY, Peter, 2004: "The Anatomy of Despair"; *New Scientist*, *182* (2445), 1 May: 43 – 45.

5 CAREY, Nessa, 2012: "Epigenetics: The missing link in the nature/nurture dichotomy?" *Ethical Record* (London), *117* (10), Nov.: 14 – 16.

6 *Darkness Visible*: 38.

7 Besides tricyclics (TCAs), other classes of antidepressants are tetracyclics (TeCAs); monoamine oxidase inhibitors (MAOIs, of which there are various types including irreversible and reversible); serotonin norepinephrine reuptake inhibitors (SNRIs); and selective serotonin reuptake inhibitors (SSRIs). There are others (e.g. NDRIs, NRIs).

8 Moclobemide (MAOI-RIMA), fluoxetine ("Prozac", SSRI), mirtazapine (TeCA) and paroxetine (SSRI), in that order.

9 *Darkness Visible*: 7.

10 *Darkness Visible*: 9 – 10.

11 *Becker*, Ernest, 1975: *The Denial of Death* (New York): 210.

Many thanks: I am once again most grateful to Sabine Apel and Halina Strnad for reading through and commenting on drafts of this talk.

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Reading time: about 33 to 34 minutes

Based on an article written in 2003 with additions in 2004 and 2005.
Revised and reworked as a talk, December 2012 & January 2013.
This version: 19 Jan. 2013

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