

# Depression

## Guidelines for depression

This guideline gives general guidance only and cannot replace clinical judgement in individual cases.

### Prevalence

- ❑ 4 out of 5 people who receive health care for depression are treated entirely in primary care.
- ❑ Lifetime risk of depression is 19% for women and 10% for men.
- ❑ In Gloucestershire men are two and a half times more likely to die from suicide.
- ❑ 21/1000 (males 17, females 25 (1992) rising to
- ❑ 98/1000 (males 71, females 124 (1996)

### Recognition

Only a minority of people present with 'clear cut' symptoms. The following factors indicate higher risk of depression. Some patients may be reluctant to admit they are depressed. Open questions, unhurried style and a warm empathetic manner can foster confidence.

- ❑ Unexplained physical symptoms
- ❑ Frequent attendees

- ❑ Drug and alcohol users
- ❑ Recent major life events
- ❑ Concurrent physical illness; terminal and painful debilitating diseases
- ❑ Living alone
- ❑ Family history of depression
- ❑ Unemployed
- ❑ Lack of supportive relationships
- ❑ Abusive relationships

### Diagnosis

The following core symptoms of depression should be present for at least 2–4 weeks.

They include:

- ❑ Low mood
- ❑ Loss of interest or pleasure in usual activities

Plus at least three of:

- ❑ Loss of energy and fatigue
- ❑ Insomnia or hypersomnia
- ❑ Loss or increase of appetite and weight

- ☐ Impaired concentration
- ☐ Retardation or agitation
- ☐ Feelings of guilt or self-blame
- ☐ Feelings of worthlessness or loss of confidence
- ☐ Suicidal thoughts or ideas.

**Mild depression** – less than 4 core symptoms are present.

**Moderate depression** – 5–6 core symptoms are present.

**Severe depression** – 7 or more core symptoms (present) plus major functional impairment (inability to perform normal daily activities) with or without psychotic symptoms.

### *Check for differential diagnosis*

Suggest baseline blood test in refractory cases and pre-referral inc FBC, B12, Plasma Viscosity, U&E, LFT, TSH and Glucose.

### *Suicide*

Patients with depression have a 25–50% lifetime risk of attempting suicide. Other high-risk groups include:

- ☐ Young men
- ☐ African/Asian women
- ☐ People who deliberately harm themselves
- ☐ People who misuse drugs and alcohol
- ☐ Older age adults

Asking about suicidal thoughts does not make suicide attempts more likely. Questions that could routinely be asked include:

- ☐ Have you had any thoughts about harming yourself?
- ☐ Do you have thoughts that life isn't worth living anymore?
- ☐ Have you ever felt that you would like to go to sleep and never wake up again?"

- ☐ Explore hopelessness – it is a valuable predictor of suicide.

If the patient has definite intentions, actual plans or previous history – refer/consult urgently with the Specialist Mental Health Services.

### *Screening*

Screening should be undertaken in primary care and general hospitals settings for depression in high-risk groups – for example, those with a past history of depression, significant physical illness causing disability, or other mental health problems such as dementia. Opportunities include:

- ☐ **New patient checks.** Patients should routinely be asked about any previous mental health difficulties (note family history)
- ☐ **Over 75s check.** Depression is common in the older age adult and is closely linked to social isolation. Early referral to day-centres/community facilities can help address the underlying causes. The Royal College of General Practitioners recommends the use of the Geriatric Depression Scale (GDS), but consider screening for dementia if depression doesn't improve quickly once treatment is initiated. **For further details see page 00.**

*Screening tools, for example, the General Health Questionnaire (GHQ) and Hospital Anxiety and Depression Scale (HAD) are valuable and validated detection tools in Primary Care.*

# Treatment guidelines for depression

## Patient

Level of depression identified (see diagnosis).  
Screening should be undertaken in primary care and general hospital setting for depression in high-risk groups

*If at risk of suicide consider:*

- ▶ Urgent referral to Community Mental Health Team
- ▶ Admission
- ▶ Mental Health Act Assessment

## Mild depression

### Treatment options

- ▶ Educational information
- ▶ Guided self-help using CBT techniques
- ▶ Short-term psychological treatment
- ▶ Support and problem solving within the PHCT
- ▶ Self-help Groups
- ▶ Community Services (see Resource Directory)
- ▶ Physical Activity/exercise
- ▶ Counselling
- ▶ Watchful waiting – re-assess in 2 weeks

Antidepressants should only be considered in mild depression when  
a) Patient presents with mild depression yet has a history of moderate to severe depression; b) Patient has not responded to other interventions; c) Patient has significant psychosocial or other stressors.

## Negotiate a treatment plan

Mutually agreed treatment goals are essential and help to ensure compliance.

## Moderate depression

### Treatment Options

- ▶ Antidepressants are considered the treatment of choice in moderate depression. Medication should be offered routinely before any psychological interventions.
- ▶ Cognitive Behavioural Therapy is the psychological treatment of choice for patients with moderate depression.
- ▶ Interpersonal psychotherapy (limited evidence base) should be considered if the patient expresses a preference or if you feel the patient may benefit.

Drug treatments and psychological therapies are not mutually exclusive and a combination of the two has been shown to be beneficial. CBT could be tried on its own for those patients who refuse or who are intolerant to antidepressants

## Monitor regularly

Patients on medication should be monitored regularly. Those with patients not considered to be at risk of suicide should be seen 2 weeks after starting treatment and regularly thereafter. Those potentially at risk or under the age of 30 should be monitored 1 week after starting treatment and regularly thereafter until the risk is no longer significant.

### At each review check:

- ▶ Response to medication
- ▶ Compliance
- ▶ Side effects
- ▶ Suicide risk

## Severe depression

### Treatment Options

Antidepressants are a first line treatment for severe depression, irrespective of environmental factors.

Severe depression is unlikely to respond to psychological input until medication has improved symptoms and mood has lifted.

## Antidepressant treatment

Optimum effects of antidepressants are not reached for at least 4 weeks. If a partial response is seen the decision to switch to an alternate antidepressant should be postponed until 6 weeks.

Treatment should continue for at least 6 months after remission in moderate to severe depression. Continue treatment for 2 years in those patients who have had 2 or more episodes in the recent past who have experienced significant functional impairment during these episodes

## Essential patient information

### Explain depression:

- ▶ It is a common illness
- ▶ It is treatable, with good outcomes
- ▶ It has a biochemical basis
- ▶ Talking can make you feel better and help to sort out problems
- ▶ Antidepressants are not addictive\*
- ▶ What side effects are expected, these usually disappear within 1–2 weeks
- ▶ Benefits of medication should occur within 2–6 weeks

\* but some may need slow withdrawal to reduce risk of Discontinuation Syndrome

## Relapse prevention strategy

- ▶ Reduce doses gradually over a 4-week period, according to patient need. For mild discontinuation symptoms reassure the patient and monitor symptoms. For more severe symptoms consider re-introducing the drug at the effective dose (or another anti-depressant with a longer half life from the same class), then reduce gradually whilst monitoring.
- ▶ Identify potential early warning signs and, if possible, involve carers.

## Refer to specialist Mental Health Services

- ▶ If no response to medication &/or other interventions.
- ▶ If suicide risk identified.

Reviewed using NICE Guidance published, December 2004.

# Antidepressant therapy decision tree

## Presenting patient

Consider non-drug psychological approaches for mild depression, and as an adjunct to moderate and severe depression.

- Is the patient at significant risk of suicide, or harm to others?
- Are there psychotic symptoms?
- Are there complex management issues?
- Is the diagnosis uncertain?

YES

Refer to specialist care for opinion or resources that are only available through psychiatric services.

NO

- Is the patient elderly? 65 years

YES

The dose of antidepressant medication needs to be titrated up to an age appropriate dose for a minimum of 6 weeks. If a partial response is seen then the medication should be continued for a further 6 weeks.

NO

Prescribe a recognised effective dose of antidepressants (after titration if necessary)  
eg. SSRI, SNRI, NASSA, NARI. NICE recommend SSRIs in routine care because they are as effective as TCAs but less likely to be discontinued due to side effects.

## Week 2

- Is the patient experiencing unacceptable side-effects?

YES

Change to drug with different side-effects profile (consider a different class).

NO

## Week 4–6

- Provide support.
- Is the patient demonstrating a response to the antidepressant prescribed? (If partial response go to NO)

NO

**Response to first antidepressant** Has the patient taken the drug regularly at the prescribed dose?  
**Partial response** If the response to a standard dose is inadequate and there are no significant side effects consider a gradual increase in dose in line with the schedule suggested in the Summary of Product Characteristics (\*1).  
**No Response** Consider switching to another SINGLE antidepressant if there has been no response after one month. If there has been a partial response postpone the decision until 6 weeks. Choices for a second antidepressant include a different SSRI or mirtazepine other alternatives include moclobemide, reboxetine, TCAs (except dosulepin \* 2). Be aware of the interactions between serotonergic antidepressants and the risk of serotonin syndrome when switching from one antidepressant to another – a wash out period may be required.

YES

## Week 8–10

- Is the patient well, or beginning to get back to their normal level of functioning (including family relationships, functioning at work and interest in outside activities)?

NO

Check drug has been taken regularly at the prescribed dose. This would be an important point to cover prior to any dosage adjustments.

YES

## Every 6–8 weeks thereafter

- Continue to provide support and motivation to ensure compliance.
- Attempt to follow-up on non-attenders and encourage them to attend – as with chronic diseases.
- Encourage continued use of self-help strategies.

**Response to second antidepressant**  
Is the patient experiencing unacceptable side effects?  
OR  
Is the patient experiencing no response from the antidepressant?

NO

Provide support and titrate the dose of drug to therapeutic dose in line with the schedule suggested in the Summary of Product characteristics.

YES

Refer to specialist care for opinion.\* Check bloods.

If the patient demonstrates response, monitor to get the patient well again.

\*1 For the majority of SSRIs in the treatment of depressive illness clinical trial data do not show any benefit in increasing to dose above the daily-recommended dose. Good practice would be to maintain patients on lowest efficacious dose.

\*2 Dosulepin should not be used routinely because the evidence supporting its tolerability is outweighed by the increased cardiac risk and toxicity in overdose

## Principles for prescribing antidepressant drugs

The value of antidepressant drugs in mild depression has not been proven and antidepressants should only be given if the depression persists.

### Choice of drug

#### Tricyclic antidepressants (TCAs) versus Selective Serotonin Reuptake Inhibitors (SSRIs)

Evidence suggests that there are no clinically significant differences in effectiveness between different kinds of antidepressant drug. However, the drugs differ in their adverse event profiles. An SSRI is less likely to be discontinued because of side effects. It is also the treatment option recommended by NICE published guidance December 2004 – Depression: management of depression in primary and secondary care – clinical guideline 23, NICE.

- ❑ The choice of drug should depend on individual patient factors such as:
  - The desirability or otherwise of sedation or other effects associated with a particular drug
  - Co-morbid psychiatric or medical conditions including suicide risk
  - Concurrent drug therapy
- ❑ SSRIs and related drugs are slightly better tolerated than tricyclic antidepressants, reducing the risk of drop out by about 4% during the first 6 weeks of treatment.
- ❑ MAOIs other than moclobemide have considerable side-effects and are unlikely to be appropriate for initiation in Primary Care.
- ❑ Moclobemide is less prone to dangerous side-effects and appears to have similar tolerability and efficacy to other available antidepressants.

#### Tricyclic and related antidepressant drugs (TCAs)

- ❑ Lofepramine has minimal side-effects, impairment of memory and concentration compared to amitriptyline and Doxepin. Can be alerting and is safer in overdose. Should not be used in patients with hepatic impairment.
- ❑ Avoid TCAs where there is risk of suicide with the exception of lofepramine which has a similar fatality rate as SSRIs.
- ❑ Trazodone offers the unusual combination of sedative properties with relative safety in overdose. Safer in epilepsy than amitriptyline.
- ❑ Amitriptyline and Doxepin are effective TCAs but have potent anticholinergic, sedative and weight gaining properties and are toxic in overdose.
- ❑ Doxepin should not be used routinely because the evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and its toxicity in overdose.
- ❑ Avoid in Ischaemic heart disease, prostatism and glaucoma.
- ❑ All antidepressant drugs lower seizure threshold although TCAs probably more so.

#### Selective Serotonin Reuptake Inhibitors (SSRIs)

- ❑ SSRIs are generally well tolerated and efficacious. There is no evidence to suggest clear superiority of one drug over another. Choices should be made on the grounds of patient's co-morbid medical conditions, susceptibility to specific side-effects and best value.
- ❑ SSRIs may be preferred where there is a major risk of overdose as they are less cardiotoxic in overdose than TCAs.

- ☐ Therapeutic dose of some SSRIs is higher than starting dose.
- ☐ Use with caution in epilepsy.
- ☐ There is no evidence to suggest that SSRIs have a speedier onset of action.
- ☐ Paroxetine has close links with Discontinuation Symptoms.
- ☐ Fluoxetine is efficacious. Its long half-life may be of benefit in poorly compliant patients and probably explains why withdrawal reaction occurs least often with fluoxetine.
- ☐ Citalopram or Sertraline may be good choices for patients on multiple drug therapy as they have a lower potential for drug interactions.

### *Other antidepressant drugs*

- ☐ A wide range of other classes of antidepressants are available.
- ☐ Reboxetine is from the NARI class. May be suitable for patients with poor motivation and impaired social function.
- ☐ Venlafaxine is from the SNRI Class. It has a positive dose response curve giving the opportunity of dose titration to achieve optimum effect. It may increase blood pressure, especially at high doses. May be useful at doses of 150mg/day and above in resistant cases. BP monitoring is essential. It is also available in modified release which may improve concordance.
- ☐ Venlafaxine should be initiated only by specialist mental health medical practitioners, including general practitioners with a special interest in Mental Health. It should be managed only under supervision of specialist mental health medical practitioners, including general practitioners with a special interest in mental health. Venlafaxine may be considered for patients who have failed two adequate trials of alternative

antidepressants. The dose can be increased up to BNF limits if required, provided patients can tolerate the side effects. Before prescribing Venlafaxine carry out an ECG and measure Blood Pressure. When prescribing Venlafaxine be aware of: a) increased likelihood of patients stopping treatment due to side effects compared with equally effective SSRIs; b) its higher cost; c) its higher propensity for discontinuation/withdrawal symptoms if stopped abruptly; d) its toxicity in overdose.

- ☐ MAOIs and RIMAs are used less frequently than TCA and related or SSRI and related antidepressants. They should be reserved for refractory depression only.

### *Other*

NICE guidance states that St Johns Wort may be of benefit in mild depression but it should not be prescribed or advised because of the uncertainty about appropriate doses, variation in the nature of preparations and potential serious interactions with other medicines.

Patients should be told about the different potencies of the various preparations and the uncertainty that arises from this, and about the interaction of St Johns Wort with other drugs (including oral contraceptives, anticonvulsants and anticoagulants).

### *Toxicity and safety of antidepressants*

- ☐ The SSRIs, NARI, NASSA and Lofepramine are associated with the smallest risk of fatal poisoning.
- ☐ If brief agitation develops in early treatment with an SSRI, provide appropriate information and, if the patient prefers, change to a different antidepressant or consider a brief trial of a concomitant benzodiazepine followed by a clinical review within 2 weeks.

## *Pharmacological treatment of atypical depression*

- ☐ Treat patients with atypical features of depression with an SSRI.
- ☐ If there is no response and there is significant functional impairment, consider referral to a mental health specialist.

## *Effective doses of antidepressants*

- ☐ The therapeutic dose is not always the same as the starting dose. This applies to both TCAs and SSRIs and related drugs.
- ☐ The dose of tricyclics should be titrated up to the recommended therapeutic dose.
- ☐ Lower doses should be used initially in older people if they are physically infirm.
- ☐ If compliance is a concern, Tricyclic antidepressants can be given in a once daily dosage as can many of the other antidepressants including Venlafaxine, Duloxetine, Paroxetine, Citalopram etc

## *Switching from one antidepressant to another*

When switching from one antidepressant to another, be aware of the need for gradual and modest incremental increases in dose, of interactions between antidepressants, and the risk of serotonin syndrome when combinations of serotonergic antidepressants are prescribed. Features include confusion, delirium, shivering, sweating, changes in blood pressure and myoclonus.

## *Stopping or reducing antidepressants*

- ☐ Inform the patient about possible discontinuation/withdrawal symptoms on stopping or missing doses or reducing the dose. The symptoms can be mild and self-limiting although they can often be severe if the drug is stopped abruptly.

- ☐ Reduce doses gradually over a 4-week period; some people may require longer periods and fluoxetine can usually be stopped over a shorter period.
- ☐ For mild discontinuation/withdrawal symptoms, reassure the patient and monitor the symptoms
- ☐ For severe symptoms consider re-introducing the original antidepressant at the effective dose (or another antidepressant from the same class with a longer half life) and reduce gradually whilst monitoring the symptoms.

# Depression checklist

- A. Low mood/sadness
- B. Loss of interest or pleasure
- C. Decreased energy and/or increased fatigue

If YES to any of the above, continue below:

- 1. Sleep disturbance 
  - Difficulty falling asleep
  - Early morning wakening
- 2. Appetite disturbance 
  - Appetite loss
  - Appetite increase
- 3. Difficulty concentrating
- 4. Psychomotor retardation or agitation
- 5. Decreased libido
- 6. Loss of self-confidence or self-esteem
- 7. Thoughts of death or suicide
- 8. Feelings of guilt.

## Summing up

Positive to A, B or C and at least four positive from 1–8 all occurring most of the time for two weeks or more.

Indication of **depression**

## Note

If there is more than one disorder present:

- best to treat an alcohol problem first if present.
- if low mood, treatment for depression takes priority over anxiety.
- if anxiety symptoms present, treatment for anxiety takes priority over unexplained somatic complaints. The latter increases in the presence of depression or anxiety.

If patient has an identified disorder:

- see relevant guideline to help determine treatment plan.
- use relevant handouts with the patient to help explain the disorder.
- provide self-help leaflets and explain how this should be used.
- set up a follow up visit(s) to review treatment.

If patient appears to have subthreshold disorder(s):

(Positive responses to many questions, but not enough to fulfil the diagnostic criteria for a disorder):

- medication may not be necessary.
- use the relevant advice and support to patient and family section of the guidelines and provide patient leaflets.
- use relevant handouts with the patient to help explain the disorder.
- indicate that you are available for consultation should the need arise.
- refer to mental health gateway nurse for further assessment or follow-up, if available in your surgery.

*WHO Guide to Mental Health in Primary Care 2004. London: Royal Society of Medicine Press.*

# Patient fact sheets

## Depression: Factsheet 1

### Depression is an illness – it is common and treatable

Depression does not mean that you are weak or lazy. It is a common illness like hypertension, diabetes or arthritis. It can occur at any age. The good news is that there are treatments that work well.

### What is depression?

Many people use the word 'depression' to describe feelings of sadness and loss. These feelings often pass within a few hours or a few days. During this time people are able to carry on much as usual. The illness which your doctor calls depression is different from this. You feel sad much more intensely and for longer. It is common to lose interest in things that you used to enjoy. Depression commonly interferes with your work, social and family life.

Depression can also affect people in many other ways. Common symptoms are:

- Disturbed sleep
- Changes to appetite
- Physical aches and pain

- Lack of energy or motivation
- Irritability and intolerance
- Feelings of guilt
- Loss of concentration

### What may trigger depression?

It is known that there are changes in the level of certain chemicals in the brains of people who are depressed. There is also evidence that if your close blood relatives suffer from depression, you are at a greater risk of having depression. For many people, depression is triggered by stressful events, alcohol or drug use. In others, a physical illness or medication causes symptoms of depression. However, in some people there is no obvious trigger. Think about your situation – was your depression associated with one of the triggers listed below?

If so, put a check beside it. If not, and you are aware of some other trigger, write it in the space provided. It would help to discuss this with your doctor, your family and friends.

#### Possible triggers

- Moving house
- Loss of job

Divorce of separation	<input type="checkbox"/>
Poverty	<input type="checkbox"/>
Death of a loved one	<input type="checkbox"/>
Long term alcohol use	<input type="checkbox"/>
Certain medications	<input type="checkbox"/>
Dissatisfaction or conflict at work	<input type="checkbox"/>
Widowhood	<input type="checkbox"/>
Chronic physical illness	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>
Chronic drug use	<input type="checkbox"/>
Seasonal changes	<input type="checkbox"/>
Loneliness	<input type="checkbox"/>
Marital problems	<input type="checkbox"/>
Childbirth	<input type="checkbox"/>
Being a victim of a crime or an accident	<input type="checkbox"/>
Unsatisfactory relationships with family or friends	<input type="checkbox"/>
Serious injury or illness in the patient or a loved one	<input type="checkbox"/>
Unprepared social and cultural changes (immigration)	<input type="checkbox"/>
Low self-esteem	<input type="checkbox"/>
Others (specify)	<input type="checkbox"/>

## How is depression treated?

Since depression commonly involves stressful events and may also involve changes in body chemistry, depression is usually best treated by a combination of medical and psychological (or talking) treatments. Medical treatment includes antidepressant medication and psychological treatments include Cognitive Behavioural Therapy, and learning how to cope with stress.

If you are experiencing the symptoms of depression it is advisable to talk to your doctor.

### 1. Antidepressant medication

These drugs will usually relieve depression in most people and may help to prevent relapse of the illness. However, unless episodes of depression occur very frequently, most people do not take antidepressant medication every day of their lives. They only take the medication when they are depressed and continue taking the medication for at least 6 months to one year after recovery.

#### How long do these drugs take to work?

Antidepressants do not relieve your depression straight away. These drugs take some time to have an effect on your mood. In the first few days some types of drugs are most likely to help with sleep and tend to have a calming effect, sometimes making people feel very tired and weak. However, after a week or two of taking the medication regularly this calming effect gives way to increasing alertness and energy. It may take up to eight weeks before the maximum benefits of antidepressant medication are noticed. Therefore, you should not expect to notice the benefits from this medicine too quickly.

There are a number of different types of antidepressant drugs. Ask your doctor for further information about these drugs and their side effects or look them up on the internet at [www.nmhct.nhs.uk/pharmacy](http://www.nmhct.nhs.uk/pharmacy)

You will also find the answers to commonly asked questions, for example:

- How long does it take to work?
- How does it work?
- Will it interact with my other drugs?
- What are the side effects?
- Is it addictive?
- What if I miss a dose?

- Will I put on weight?
- Can I drink alcohol?
- Do I have to avoid any foods?
- Will it affect my sex life?
- Will they make me drowsy?
- Will I need a blood test?
- How long will I have to take it?
- Will it affect me taking the contraceptive pill?
- Will I be able to drive?
- What if I become pregnant?
- Can I stop taking them suddenly?

## 2. Psychotherapy (talking treatments or counselling)

There are a number of different kinds of psychotherapy that are useful for people who are depressed. The following information outlines three useful forms of psychotherapy.

### Cognitive therapy

People who are depressed tend to feel as if they are a hopeless failure. When something bad happens they blame themselves, but when good things happen they tell themselves they are just lucky. Furthermore, depressed people tend to believe that things will never get any better. Cognitive therapy aims to help people identify their negative ways of thinking and to teach them how to think in a more positive and helpful way. People learn that they have some control over what happens to them. They learn to bounce back from failure more effectively and to recognise and take credit for the good things in their lives.

### Behavioural therapy

Depressed people tend to have trouble motivating themselves. They often sit for hours, thinking about their problems and missing out on good opportunities. Behaviour therapy aims to identify and change aspects of behaviour that may cause or prolong

symptoms of depression. Some forms of behavioural change include activity planning, problem solving, goal planning, and social skills training.

### Interpersonal therapy

This form of therapy aims to help people resolve one or more of their interpersonal problems that may be causing or prolonging symptoms of depression. For example, interpersonal therapy may help you cope with prolonged grief reactions after the death of a loved one, adjustment to new life situations such as parenthood or divorce, or may help with the resolution of interpersonal disputes (eg, marital problems or disputes with colleagues at work).

## Coping with depression

The following guidelines are designed to help you cope more effectively with the symptoms of depression.

### *Loss of interest, slowed activity, lack of energy*

When you're depressed, it's often hard to get any enjoyment or pleasure out of things. As a result, you may have stopped doing things you used to enjoy. Having nothing enjoyable in your life then helps keep the depression going. It often helps to slowly get back into your routine and also to increase the number of things that you enjoy. Your doctor, counsellor or friend can help you.

### *1. Identify things you used to do regularly and things which you used to enjoy*

Write down the things you did every day (or every week) before you were depressed. Now think about the things you enjoyed doing and those that you wanted to do and write them down too. You might want to talk about these with someone else.

### Before becoming depressed my:

- ☐ routine activities, eg grocery shopping

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- ☐ pleasant activities, eg going for a walk

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- ☐ activities I wanted to do, eg reading

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## 2. Plan to gradually increase the routine and pleasant activities

Once you have identified your daily routine activities and pleasant activities, with the help of your doctor, counsellor or friend, you can slowly try to return to your routine and also try to do some of the pleasant activities you enjoy. At the beginning of each week you can choose activities from your 'daily routine' list and 'pleasant activity' list and build them into your day.

## 3. If a task seems too difficult, try breaking it into a series of small steps

Set yourself the goal of completing one step at a time. For example, making a flower bed can be broken down into a number of smaller tasks:

- ☐ Choose some new plants
- ☐ Pull out the old plants (need gloves and spade)
- ☐ Prepare the soil (need compost and fertiliser)
- ☐ Put in the new plants.

## 4. Above all reward yourself for your efforts

Ask others around you to encourage and praise you for each small step you take. Recovering from depression is a bit like learning to walk again after breaking your leg.

Remember, it is important to do these activities even when you do not feel like it. Getting going again can help you feel better.

## Loss of appetite

Eat small portions of food that you particularly like. Take your time and do not feel under pressure to finish if you are eating with others. Drink plenty of fluids, especially fruit juices and milkshakes.

## Sleep disturbance

- ☐ Get up at the same time every morning.
- ☐ Avoid sleeping during the day.
- ☐ Reduce tea and coffee intake if excessive (no more than two to three cups per day and none after about 4 pm).
- ☐ Do not lie awake for more than about 30 minutes – get up and find a relaxing activity.
- ☐ Try relaxation exercises. Ask your clinician for more information about these exercises. Your health worker can give you more information about managing sleep difficulties.

## Loss of interest in sex

Seek non-sexual activities with your partner that you still enjoy. Explain to your partner that your loss of interest and affection is a symptom of your depression, not a rejection of him or her, and that these symptoms will be temporary.

## What is depressive thinking?

When you are depressed there are changes in the way you think, as well as in how you feel. You tend to look on the black side of everything, see the worst in yourself, in your life and your future. Once you are feeling down, you are more likely to remember the bad things that have happened and ignore the

good ones. Negative thinking can also trigger depression and it slows down recovery. Everyone has negative thoughts, but they also have positive ones. A healthy balance seems to be about two positive thoughts to 1 negative one. When you are depressed, this balance is disturbed. You may also have thoughts that are distorted and don't fit the facts, such as 'I am a waste of space' and 'I am a complete failure'.

**Have you noticed differences in the way people think about events? Can you relate to the example below?**

A colleague was promoted at work rather than you...

Person A

*Person B*

She is more experienced  
*I will never get promoted*

She has been here longer  
*I am not appreciated*

She has the necessary skills  
*I am not liked*

It will be my turn next time  
*I am worthless*

Disappointment  
*Prolonged unhappiness*

**Learning to recognise unrealistic, negative thoughts and to balance them with more realistic, positive ones can be very helpful. However, changing your way of thinking is quite difficult at first and you will need to keep working at it. It may help to enlist the help of someone you trust.**

## Identifying negative thinking

Negative thoughts can be difficult to spot because they become a habit, they can flash quickly into your mind and most of us are not used to noticing our thoughts. Learning to spot and catch these negative thoughts is a skill you can master with time.

When you are depressed, you tend to think in particular ways that are distorted in a negative way. These are called 'thinking errors'. Here are some common examples. Try to spot the ones which apply to you. Mark them in the box.

- Thinking the worst, eg your boy/girl friend doesn't phone. You assume they don't like you any more.
- Thinking that everything is going wrong when only one thing has gone wrong (over-generalising). For example, you make one mistake at work and think 'I'll never succeed. I can't do anything'.
- Ignoring the positive and only seeing the negative, eg 'The shelves I put up are no good because a screw fell out.'
- Arguing away anything positive, eg 'He said he liked what I did because he is sorry for me'.
- Making negative predictions, eg 'It's no good my doing that, I'm bound to fail. It will be a disaster'.
- Taking things personally and blaming yourself for what others do, eg 'My son failed that exam. I should have helped him more. I am a bad parent' or 'My partner has left me. I am no good'.
- Exaggerating the negative, eg 'This is a complete disaster, a total failure'.

You may also have beliefs about yourself and about how the world is and should be that are unrealistic. These beliefs may be making it harder for you to deal with the problems in your life and so may be contributing to your depression. Here are some examples of beliefs that make people more likely to get depressed.

- I should be happy all the time.
- To be a good person, I have to be nice to everyone.
- If someone is hurt by something I say or do, I am a bad person.

- ☞ If I show emotion, it means that I am weak.
- ☞ It is shameful for me to show any sign of weakness.
- ☞ If someone does not like me, it means there is something wrong with me.
- ☞ If I argue or disagree, people won't like me.
- ☞ If I am criticised, it means I am wrong.
- ☞ If I don't succeed, I am worthless.
- ☞ I cannot handle it when things go wrong.

## Changing negative thinking

It is likely that you have been thinking in a negative way for sometime now. It will take a lot of practice to change these ways. You may find it quite difficult at first and this may trigger more negative thoughts, such as 'I'm useless. I can't do anything right'. You may need help from a friend or from your health worker. Give yourself time. **Remember you can learn to think more positively and this will make a huge difference in your life.**

### *Here are some suggestions:*

First, write down your negative thoughts as soon as possible. If it's difficult to notice any thoughts, try noticing when you feel down and ask 'What went through my mind just before I started feeling sad'.

### *Second, ask yourself 'Is what I believe TRUE?'*

- ☞ It will be useful to consult someone outside the situation for their opinion
- ☞ Ask yourself if everyone would have the same belief in this situation
- ☞ Examine other possible explanations for the event occurring
- ☞ Ask yourself if you could be making a mistake in the way you are thinking

- ☞ Try a real-life experiment. For example, if your friend doesn't phone, call him or her to ask why. Check out if your assumption that he or she no longer likes you is true.

### *Third, balance each negative/unreasonable thought with more realistic ones*

- ☞ These should be different to the unreasonable belief
- ☞ Try to make them realistic statements
- ☞ Try to make as many counters as possible

Now, read the following example and work out your own examples using the same format. You can do this with the help of your friend, doctor and/or your counsellor.

### *Example*

The example below shows how negative and positive thoughts lead to different reactions to the same situation.

#### **SITUATION: Was not chosen for job**

Unreasonable/negative thoughts:

- ☞ Just as well I didn't get the job, I would have failed at it anyway
- ☞ I am no good/stupid
- ☞ I am a failure
- ☞ I should give up
- ☞ I will never succeed.

#### **Resulting feelings: Worthlessness, depression.**

Now lets look at the same situation from a different angle:

Reasonable/positive thoughts:

- ☞ Many people do not get the job they want
- ☞ I need to practice some interview techniques
- ☞ I am not a failure, I have achieved many good things in the past

- ☐ I will not get anywhere by giving up
- ☐ If I persevere I can succeed
- ☐ I have succeeded in the past and I will continue to succeed

**Resulting feelings: Disappointment, but enthusiasm and hope.**

Now you can work through your own examples. Write down a situation that has made you unhappy and any negative thoughts you may have had and the resulting feelings. Next, opposite each negative thought, write down a more balanced thought and any new feelings. You will find that after practising this technique for a while, you get much better at balancing your thoughts.

## Positive thinking

- ☐ Make a list of your three best features – perhaps with the help of a friend or relative. Carry the list with you and read it to yourself whenever you find yourself focusing on negative thoughts.
- ☐ Keep a daily record of all the small pleasant things that happen and discuss these events with your friends when you see them.
- ☐ Recall pleasant occasions in the past and plan pleasant occasions for the future (this may best be done in conversation with a friend).
- ☐ Identify those areas of your life that are positive. When you are depressed it is easy to lose sight of those things that you value in your life. Think about life before depression. What did you value and what was special? Make a list of them, eg:

Family \_\_\_\_\_

Children \_\_\_\_\_

Work \_\_\_\_\_

Sport \_\_\_\_\_

Music \_\_\_\_\_

- ☐ Avoid discussions about your bad feelings. Expressing unreasonable thoughts about yourself is not helpful – solving realistic problems is helpful.
- ☐ Consider alternative explanations for unpleasant events or thoughts. Although your initial explanation may be that you are at fault, rethink these conclusions and write down all other possible explanations for these events or thoughts.
- ☐ Keep yourself busy doing useful activities. Avoid sitting or lying about doing nothing.

## Dealing with worries and problems

If you find that you are worrying, endlessly turning over your different problems in your head, try putting your worry to a useful purpose. Pick out one or two problems that seem really important and make a decision to resolve them. You may like to ask a friend to help you.

Sit down with a problem solving sheet (your health worker can provide you with one) and go through the following steps:

- ☐ Say exactly what the problem (or goal) is.
- ☐ List 5 or 6 possible solutions to the problem – write down any ideas that occur to you, not merely the ‘good’ ideas.
- ☐ Evaluate the good and bad points of each idea in turn.
- ☐ Choose the solution that best fits your needs.
- ☐ Plan exactly the steps you will take to put the solution into action.
- ☐ Review your efforts after attempting to carry out the plan. Praise all efforts. If unsuccessful, start again.

Your health worker can give you more information about problem solving techniques.

## Dealing with stresses

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Depression is more common in people who have had to make major adjustments in their lives during the past year (eg death of a loved one, birth of a baby, loss of a job, or moving house). These adjustments may result in continued stress. Over time, this stress may make people vulnerable to depression. Thus, in order to fully resolve the depression and to prevent recurrence, it is important to resolve the stress.

The same problem-solving approach described in 'dealing with worries' can be used to help you deal with stress. With the help of a friend or your health worker, try to define exactly what aspects of the major change is causing the stress. For example, the birth of a baby is a major adjustment, and the aspects causing most stress for you might be difficulty getting time alone or dealing with disturbed sleep. Then go through the steps outlined above in order to devise a detailed plan to resolve the issue. There are agencies which provide specialist advice and support with particular types of problems – for example, debt or relationship problems. Your health worker may have information about these agencies or you could ask your local Citizens Advice Bureau for their addresses. The Citizens Advice Bureau is listed in the telephone directory.

Not all stresses can be fully resolved. However, there is usually some way of helping you cope better so that the impact of the stress can be reduced. For example, some chronic illnesses cannot be cured, but doing relaxation exercises may help someone to deal with the pain and support groups may be able to provide useful tips for how to live with the condition. Some communications skills, such as assertiveness training, can help people deal better with difficult relationships or situations at work or at home. Your health worker may be able to give you information about these. Many local Colleges of Further Education or Community Schools run day and evening

classes in relaxation, yoga and assertiveness skills. Support from friends and family is also very important. Now is the time to ask for and accept support.

## How to avoid recurrence of depression

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- ☑ It is very important that you follow your doctor's advice
- ☑ Take your medication as directed without skipping any days
- ☑ Never reduce or stop taking medication without first talking to your doctor
- ☑ If you have stopped doing things you used to do, gradually increase what you do and include activities you enjoy
- ☑ Use the problem solving approach to deal with problems, stresses and worries
- ☑ Work on identifying your negative thoughts and changing them to positive ones.

**Assess your symptoms regularly and consult your doctor and/or counsellor if you have any problems.**

## Summary

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- ☑ Depression is a biological disorder that is made worse by life stress.
- ☑ Depression has characteristic symptoms that affect a person's thoughts, feelings, and everyday functioning.
- ☑ Antidepressant drugs help relieve some of the symptoms but take time to work.
- ☑ You and your friends and family can help overcome depression by keeping busy, avoiding negative thinking, solving problems, and reducing stress.

*Adapted, with permission from Falloon IRH, Depression: How to Cope with it, Buckingham Health Services; and Health Public Affairs, Department of Health, NSW. Living with Mood Swings - Manic Depressive Illness State Health Publication No (HP) 86-027, quoted in Andrews G and Jenkins R, eds, 1999, Managing Mental Disorders (UK edition), Sydney, World Health Organisation Collaborating Centre for Mental Health and Substance Abuse; and World Health Organisation, 1998, Mental Disorders in Primary Care: a WHO Education Package.*

# Postnatal depression

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## Introduction

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Postnatal Depression (now often referred to as 'PND') means becoming depressed after having a baby. Sometimes this is easy to explain – the baby is unwanted or abnormal. Mostly, though, the depression makes no obvious sense: 'I was so looking forward to having this baby, and now I feel utterly miserable. What's the matter with me?' 'The labour went beautifully – much better than I expected, and everyone's been marvellous, especially Jim. So why aren't I over the moon?' 'I was so afraid there'd be something wrong with her, but she's perfect. So why aren't I enjoying her? Perhaps I'm not cut out to be a mother?'

These women are not ungrateful or unmotherly: they are experiencing one of the most common complications of childbirth, from which too many women still suffer unnecessarily in silence – Postnatal Depression.

## How common is it?

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Very! Again and again it has been found that no less than one in ten women suffer depression after childbirth. This blight on the experience of motherhood is therefore one of the most common illnesses following childbearing. It can go on for months, or even years, yet if treated soon enough it can be nipped in the bud.

## Symptoms

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### *Depression*

This is the most common symptom of PND. It means feeling low, unhappy and wretched for much or all of the time. Sometimes the depression is worse at particular times of the

day, like mornings or evenings. Sometimes there are good days and bad – which are the more disappointing because the previous good day raised hopes of getting better.

Sometimes it can seem that life is not worth living, at a time when it should be at its most joyous.

### *Irritability*

Often accompanies the depression. It can be shown towards any other children, and occasionally the baby, but most of all the partner, who may well wonder what on earth is wrong!

### *Fatigue*

All new mothers get pretty weary, but the depressed mother is so utterly exhausted that she may think that there is something physically wrong with her.

### *Sleeplessness*

However, when at last she gets to bed she may find that she cannot fall asleep – or if she does, that she wakes early, even if her partner is feeding the baby that night.

### *Loss of appetite*

Depressed mothers usually haven't the time or the interest to eat, and this contributes to feeling irritable and run down. Some women, though, eat too much, for comfort, but then feel guilty and uncomfortable about getting fat.

### *Loss of enjoyment (or 'you're no fun anymore!')*

What used to be a pleasure is unappealing, what used to be of interest is a bore. This may be especially true of sex. Some women regain

interest in sex (if they ever lost it) before the 6 weeks postnatal examination, but PND usually takes any enthusiasm away. The partner who seeks to share the comfort and excitement of intercourse meets reluctance or a rebuff. This puts further strain on the relationship.

### *Not coping*

PND causes a feeling of having too little time, doing nothing well and not being able to do anything about it. A new routine, to cope with the baby as well as everything else, is hard to establish.

### *Anxiety*

Is acute. Often it takes the form of being afraid to be alone with the baby, who might scream the place down or not feed or choke or be dropped or harmed in some other way. Some depressed mothers perceive the baby as 'it', instead of feeling that they have given birth to the loveliest, most adorable creature in the world they feel detached from their infant. They can't see that it's all that beautiful – indeed, they may find it a rather strange, mysterious little being, whose thoughts (if any) can't be fathomed and whose unpredictable needs and emotions have somehow to be satisfied. The task of a new mother who hasn't yet 'fallen in love' with her baby is extra difficult. The love comes in the end, but usually when the baby is older and more interesting.

However, PND may develop even when love is strong. The mother then worries desperately in case she should lose her precious baby through infection, mishandling, faulty development or a 'cot death'. Snuffles cause her terrible worry, she frets over how much weight has been (or not been) gained, she is alarmed if the baby is crying or if it is too silent – has its breathing stopped? So she wants constant reassurance from her partner, the Health Visitor, the doctor, her family, the woman next door – anyone, really.

Anxiety may also make the mother concerned about her own health. She may panic when her pulse races and her heart thumps and then she may feel she has heart disease or be on the brink of a stroke. She feels so drained – is there some dreadful illness, and will she ever have any energy again? Her feelings are so odd and unusual – is she going mad? (The answer is NO!).

The terror of being left alone with all this can cause even the most capable woman to cling desperately to her partner, not wanting him to go to work.

Aren't all women like this after having a baby?

Thank goodness, no! Many women – at least one in two – feel a bit weepy, flat and unsure of themselves on the third or fourth day after having a baby. This is the 'baby blues', which soon passes. Of course, many women are weary and a bit disorganised when they get home from hospital, but they usually feel on top of the situation in a week or so. But for mothers with PND things get worse and worse.

## When does it happen?

Most cases of PND arise within a month of the birth, but sometimes depression appears up to six months later.

## Why does it happen?

We don't know enough about why women get PND to be sure who will or won't suffer it. Probably there isn't a single cause, but a number of different stresses may have the same consequence, or may act together. We know that among these 'risk factors' are:

- ☐ a previous history of depression (especially PND)
- ☐ lack of support from the partner
- ☐ a premature or otherwise ailing baby
- ☐ the mother's loss of her own mother when a child

- ☐ an accumulation of misfortunes, like a bereavement, the partner's losing his job, housing and money problems, etc.

However, a woman can suffer from PND when none of these apply and there is no obvious reason at all.

## What about hormones?

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It seems likely that PND is related to the huge hormone changes which take place at the time of giving birth, but this evidence is still lacking. Levels of oestrogen, progesterone and other hormones to do with reproduction, which may also affect emotions, drop suddenly after the baby is born, but no real differences have been found in the hormone changes of women who do and do not get PND. Some women, though, may be more vulnerable to such changes than others.

## Do women with PND harm their babies?

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No, they don't. They may feel like it (as, to be honest, do many mothers even without PND on occasion – 'I feel that if he goes on screaming I'll pick him up and throw him out of the window!') and they worry very much in case they should actually harm their babies, but they never do.

Women who do 'batter' their babies (the proper term is non-accidental injury, or NAI) have often been emotionally damaged by ill-treatment when they themselves were children.

Rarely, however, a baby is injured or even killed by a mother who is severely mentally disturbed at the time. This is a tragic consequence of puerperal psychosis, a very serious (but very treatable) mental illness which usually comes on within days of giving birth. The mother may be deluded that her baby is evil or, feeling suicidal, she may decide to take the baby's life with her own. This is called infanticide, rather than murder.

Puerperal psychosis arises only after one birth in 500, and infanticide is fortunately very rare.

## What can be done?

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A great deal, but first the PND must be recognised.

Many depressed mothers don't realise what is wrong with them, and are ashamed to admit that they are less than thrilled by new motherhood. They may think that if they say how they feel the baby may be taken away (it won't be). Some doctors and Health Visitors are good at spotting PND, because they know about it and look out for it, but others overlook or ignore it, or say, wrongly 'Oh, that's just the baby blues'.

Now that there is a greater awareness of depression in general, PND should be missed less often. A questionnaire with only 10 questions is now widely used and is helping Health Visitors and GPs to spot the disorder - it's called the Edinburgh Scale.

Once the condition is suspected, the mother is encouraged to say how she has really felt since she had the baby. If she says that she has felt miserable, irritable, incompetent, frightened and not all that keen on her baby this is accepted with compassion and understanding, not alarm and reproaches.

It helps many a mother to be told 'You've got PND'. At last she knows her enemy. She can be reassured that she is not a freak or a bad mother, and that many others are in the same boat. PND is very common and anyone can get it (like flu). She can then be told that she will get better, but it may take time, and that arrangements will be made to see that she is supported until she has recovered.

It is now important to bring the partner into the picture, so that he can understand what has been going on (he, too, has been suffering from PND!) and be helped to be helpful. He is usually best placed to give support, provided that he has goodwill and gets a bit of support

himself. If this is the first baby he may have been feeling pushed aside by the new arrival. If he then feels resentful without grasping how much his partner needs his support and encouragement, he may withdraw and add to her problems. He too may be hugely relieved by the diagnosis and guidance about what to do. Practical help with the baby, sympathetic listening, patience, affection and being positive will go a long way: they will be much appreciated even when at last the depression is over.

## What is the outlook if PND is not treated?

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Most women will get better anyway, after weeks, months or even a year or two. However, this means a lot of suffering. PND gets the experience of new motherhood off to a bad start, and strains the relationship with the baby's father. So the shorter it lasts, the better. It is very important to diagnose and treat PND as soon as possible.

## Can PND be prevented?

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Yes. There are three kinds of prevention: stopping it happening in the first place; nipping it in the bud; and stopping things from getting worse. This leaflet has been mainly concerned with the second form: spotting PND and treating it quickly.

We don't know enough yet about PND to prevent it in the first place, but certain principles make sense:

- ❑ **DON'T** try to be a superwoman: having a baby may be a full-time occupation, So try to reduce commitments during your pregnancy. (If you are at work, make sure you get regular and sufficient nourishment and put your feet up in the lunch hour);
- ❑ **DON'T** move house (if you can help it) while you are pregnant or until the baby is six months old;
- ❑ **DO** make friends with other couples who are expecting or have just had a baby; among other things, this could lead to a baby-sitting circle;
- ❑ **DO** identify someone to whom you can confide, it helps so much to have a close friend you can turn to. (If you can't easily find someone, try the National Childbirth Trust or MAMA – their local groups are very supportive before and after childbirth);
- ❑ **DO** go to antenatal classes – and take your partner with you! If you have suffered PND before, that doesn't mean that you will do so again. However, it is only sensible to keep in touch with your GP (and, after the birth, your Health Visitor) so that should there be any signs of recurrence, treatment can start at once.

## Contacts

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### National Childbirth Trust

Alexandra House, Oldham Terrace, Acton, London W3 6NH.

Tel: 0208 993 4537

between 9.30am and 4.30pm, Mon to Fri.

Information and support in pregnancy, childbirth and early parenthood.

### The Samaritans

National helpline: 0845 90 90 90

National organisation offering support to those in distress who feel suicidal or despairing and need someone to talk to. They have 204 branches around the country open 24 hours a day, every day of the year. The telephone number of your local branch can be found in the telephone directory.

**Meet a Mum** – [www.mama.co.uk](http://www.mama.co.uk)

**Cry-Sis** – Tel: 0207 7404 5011

**Association for Postnatal Illness** –

Tel: 0207 386 0868

**Also The National Childbirth Trust** –

Tel: 01242 254577

## Books

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*Banish Baby Blues*, by A. M. Sapsted.  
Thorsons Mail Order, Harper Colins, Westerhill  
Road, Bishopbrigg, Glasgow G64 2QT.

*Down with Gloom!* by Brice Pitt, drawings by  
Mel Calman. Gaskell Press, The Royal College  
of Psychiatrists, 17 Belgrave Square, London  
SW1X 8PG.

*Coping with Postnatal Depression*, by Fiona  
Marshall, Sheldon Press, SPCK Mail Order, 36  
Steep Hil, Lincoln LN2 1 LU.

*March 2001. Reproduced by kind permission  
from the Royal College of Psychiatrists*

*Surviving Postnatal Depression: At Home, No  
One Hears You Scream*, by Cara Aiken, Jessica  
Kingsley Publishers Ltd, London.  
ISBN 1-85302-861-4

*Feelings after Birth: The NCT Book of  
Postnatal Depression*, by Heather Welford,  
The National Childbirth Trust, London.  
ISBN 0-9543018-0-3

## Useful websites

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[www.maternityalliance.org.uk](http://www.maternityalliance.org.uk)  
produce a factsheet on women's rights if they  
have PND and are returning to work.  
(Maternity Alliance Tel: 0207 490 7639)

[www.fathersdirect.com](http://www.fathersdirect.com)  
information for fathers on PND but a login is  
required so I haven't been able to see the  
information.

[www.mothersformothers.fsnet.co.uk/  
services.html](http://www.mothersformothers.fsnet.co.uk/services.html)  
Very useful and informative website about  
PND although their telephone helpline is only  
available to mothers in south Gloucestershire.  
Useful links.

[www.nctcheltenham.org](http://www.nctcheltenham.org)  
Cheltenham NCT website.

# Important advice about your antidepressants

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Your doctor has given you a prescription for antidepressants. Before starting them you may find the following information useful.

- ☑ Antidepressants are NOT addictive. (Unlike tranquillisers which can be).
- ☑ Do not take more or less than your GP prescribed.
- ☑ It can take between 2–4 weeks before you feel any improvement.
- ☑ Some side effects may be experienced before you feel the benefits. These usually wear off.
- ☑ The common side effects may be dry mouth, constipation, blurred vision, nausea, headaches or drowsiness.
- ☑ These side effects can be reduced by increasing fluid intake, chewing gum, boiled sweets, etc. Increase fibre intake in the form of fresh fruit, vegetables and breakfast cereals.
- ☑ Discuss any continuing concerns with your doctor.
- ☑ Avoid alcohol.
- ☑ Treatment should be taken for 6 months–1 year after you feel better, to reduce the possibility of your illness recurring.
- ☑ Do not stop your medication without talking to your doctor.
- ☑ If you require help in addition to your antidepressants, your doctor may discuss alternative treatment options with you.

**DEPRESSION IS COMMON, AFFECTING ANY AGE, GENDER OR BACKGROUND AND RESPONDS WELL TO TREATMENT**

For more information on your particular drug visit [www.nmhet.nhs.uk/pharmacy](http://www.nmhet.nhs.uk/pharmacy)

# Resources for depression

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## National organisations

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### Depression Alliance

35 Westminster Bridge Rd, London SE1 7JB.  
Answerphone: 0207 633 0557  
National network of self-help groups,  
information)

### Fellowship of Depressives Anonymous

### Aware Defeat Depression Ltd

Depression Information Centre,  
22 Great James Street, Derry, BT48 7DA.  
Tel: 02871 260602  
(Information and support groups)

### Association for Postnatal Illness

25 Jerdan Place, London SW6 1BE  
Tel: 020 7386 0868 (Mon to Fri 10 am–5 pm).  
Network of volunteers to support sufferers  
in UK.

### SAD (Seasonal Affective Disorder) Association

PO Box 989, Steyning BN44 3HS  
Tel: 01903 814942  
(advice, information and support).

### Manic Depression Fellowship

8–10 High Street, Kingston-Upon-Thames,  
Surrey KT1 1EY  
Tel: 01224 211237

## Local organisations

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### Manic Depression Fellowship

Cheltenham 01242 260054

### Stress Management Workshops

Run across county in local colleges, proven to  
reduce anxiety and depression. 01452 504329

## Telephone support

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### Samaritans

Tel: 08457 909090 (Support for those feeling  
lonely, despairing or suicidal)

### CALM (for young men)

Tel: 0800 58 58 58

### Saneline

Tel: 0345 678 000 (Information for sufferers,  
carers or friends.)

## Help for practical problems

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### Citizens Advice Bureau

Their telephone number will be in your  
telephone directory. Provide a wide range of  
free and confidential advice and help on issues  
like, for example, social security benefits,  
housing, money problems, family and  
personal matters. They are likely to know of  
other local agencies that may be able to help  
in dealing with problems that may be  
contributing to your depression.

## Suggested reading

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**Managing Anxiety and depression: A Self  
Help Guide** by *N Holdsworth and R Paxton*.  
Mental Health Foundation 1999 (short, cheap,  
very easy to read self-help booklet)

**Managing your mind: the mental fitness  
guide** by *Gilian Butler and Tony Hope*.  
Oxford University Press, 1996 (self-help for  
depression, relationships, health and work)

**So Young, So Sad, So Listen:** by *Graham P  
and Hughes C*. Gaskell Press 1995. £5. (Book  
about childhood depression)

**Coping with Postnatal Depression:** by *Fiona  
Marshall*, Sheldon Press

**The Feeling Good Handbook: Using The New Mood Therapy in Everyday Life** by *David Burns*. Plume Book, 1990 (detailed information on how to balance your thinking)

See also Depression Leaflet published by Primary Mental Health Service.

## Audio tapes

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**Coping with Depression: Coping with Sleep Problems, Feeling Good (self-esteem/assertiveness), Coping with Pain** *available from* Talking Life, PO Box 1, Wirral L47 7DD.  
Tel: 0151 632 0662. Fax: 0151 632 1206.  
(Information and self-help)

## Classes and activities

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Leisure Centres run different kinds of exercise classes, which may help. Adult classes in yoga, meditation, relaxation and assertiveness are commonly held in local schools or in Colleges of Further Education, during the day and evening. These are not specifically for people with problems, but may help you relax and cope with stresses that may be contributing to your depression. Ask your doctor, nurse or counsellor if they think any of these are appropriate for you.

## What is Depression?

Depression does not mean that you are weak or lazy. It is a common illness like high blood pressure, diabetes or arthritis. It can occur at any age. The good news is that there are treatments that work well.



Many people use the word “depression” to describe feelings of sadness and loss. These feelings often pass within a few days. During this time people are able to carry on much as usual. The illness which your doctor calls depression is different from this. You feel sad more intensely and for longer. It is common to lose interest in things you used to enjoy. Depression commonly interferes with your work, social and family life.

**Most people recover completely from depression so you should never give up. Try to live one day at a time and keep reminding yourself that you will not always feel like this.**

## Depression

### Additional Sources of Help

[www.pmhsglos.org.uk](http://www.pmhsglos.org.uk) – Visit for further information on managing depression and other problems

Samaritans 08457 90 90 90

Relate – Relationship Counselling 01242 523215

Cruse Bereavement Services 08701 671677

Depression Alliance 02076 330557

GUIDE – Health, social care & disability information for Gloucestershire 01452 331131

Parent Line Plus – general helpline (open 24 hrs) 0808 8002222

Citizens Advice Bureau  
Monday–Friday  
Cheittenham & Tewks. 10–4pm  
Gloucester & District 9–5pm  
Cirencester 10–4pm

Stress Management Courses  
(Primary Mental Health Service) 01452 383242

Gloucestershire Farming Friends 01452 760127

Saneline 08457 678000

**BOOKS**  
**Overcoming Depression**  
by *Paul Gilbert*. Robinson, 2000

**Manage Your Mind: The Mental Fitness Guide**  
by *Gillian Butler and Tony Hope*. Oxford University Press, 1996

**Understanding Depression** by *Dr Kwame McKenzie*. Family Doctor Series (British Medical Association)  
Available from your local pharmacy

Primary Mental Health Service  
Eastgate House Ground Floor  
121-131 Eastgate Street  
Glos. GL1 1QB  
Tel. 01452 504329  
[www.pmhsglos.org.uk](http://www.pmhsglos.org.uk)

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## Depression and how to deal with it



Primary Mental Health Service  
Gloucestershire Health and Social Care Community

# Signs of Depression

When we become depressed, we may experience:

- Feelings of hopelessness, misery or despair
- Sadness, when there is maybe nothing to feel sad about
- Tearfulness, when there is nothing to cry about
- A sense of failure, when this is not realistic
- Disturbed sleep and/or changes to appetite
- Lack of energy or motivation
- Difficulty in concentrating or making decisions
- Physical aches and pains
- Loneliness, even among other people
- Extreme guilt over minor matters
- Loss of identity and self-esteem
- Thought of death or suicide

**If your low mood or loss of interest in life interferes with your home, family or work life, lasts for two weeks or more or brings you to the point of thinking about suicide, you may be experiencing clinical depression and you should seek help. Talk to your GP or contact one of the mental health associations or voluntary organisations. Both drug and talking treatments are available and can help.**

# Coping with Depression

**Practical steps to help yourself:**

- Avoid sitting or lying about doing nothing
- Identify things you used to do regularly and things which you used to enjoy
- Plan to gradually increase the routine of pleasant activities
- If a task seems too difficult, try breaking it into a series of small steps
- Make exercise a part of your daily routine
- Above all reward yourself for your efforts
- Avoid discussions of bad feelings. Solving problems is more helpful
- If appetite is poor, eat small quantities regularly and drink lots of fluids
- Keep to a normal sleep routine. Avoid daytime naps. Get up if awake for 30 mins or more — and try to relax
- If you go off sex, keep some physical closeness with partner and reassure them its not personal but a temporary symptom

**It is important to be active even when you do not feel like it. Getting going again can help you feel better**

When you are depressed there are changes in the way you think, as well as in how you feel. You tend to look on the black side of everything, see the worst in yourself, in your life and your future. Negative thinking can also trigger depression and it slows down recovery. Learning to spot and catch these negative thoughts is a skill you can master with time.

Visit [www.pmhsglos.org.com](http://www.pmhsglos.org.com) for further information and guidance.

**Having difficulty in coping with stress?**

Learn how to manage depression and/or anxiety by joining a stress management course at your local college.

**What will the workshops involve?**

The 6 weekly workshops will help you to:

- understand stress better and recognise how it affects your life
- learn coping skills such as relaxation, time management and problem solving
- think about things that you can do to relieve emotional distress
- lead a healthy lifestyle

The course will involve your participation each week but we will keep it as stress free as possible!

Contact your local college to enrol or for more information call the: Primary Mental Health Service on **01452 383242**, or visit our website [www.pmhsglos.org.uk](http://www.pmhsglos.org.uk).

The NHS runs these courses in partnership with Education

