

## Experiences of **DEPRESSION**

– Prudencio Oyarbide, LCSW  
Adult Clinical Services, Associate Manager

**D**epression is experienced by some adults as a dark cloud that cannot be shaken, coupled with a deep sadness; a sadness that is felt very much in isolation and alone. Frequently, this kind of depression reflects the grieving of losses, and grieving of the past. The mind engages in thorough analysis, often very dark and negative, about past performances and past losses. Typically they are viewed as negative performances that lead to guilt – guilt about what we did or did not do; guilt about the contribution to the present state of sadness and depression; and possibly, viewing of the depression as one's own "fault."

This state of "grieving the past," if it lasts for a short time, can be a normal response to trauma and loss. But, when this state of mind continues for a long period of time or when it is experienced as coming and going and we find ourselves unable to shake it, then we talk about non-normal or clinical depression.

### Grieving the Future

Depression is also experienced as loss for the future; about things we cannot control or things that will not be there for us. People refer to this as: "I will never be a father or mother," "I will never experience a good relationship again," "I've failed, and I will fail again." Or, they may express this in the sense of: "What is the use?," "Why should I continue to live?"

This "grieving the future" aspect of depression poses a significant risk for suicide, not only suicidal ideas or ideation, but suicidal behavior and death. To this person, the future has no meaning.

### Not having a "Right" to Exist

Many depressed individuals talk in terms of becoming a burden to society, especially to immediate caregivers and family members. When people are in this state, they not only feel guilty about their existence, but they see themselves

*"Although I knew depressed people often got locked into negative thought, I didn't see this happening to me. Even when I heard myself voice all the typical thought patterns of someone who was depressed (seeing this as being my fault, a result of my weakness, a flaw in my character, something I should have been able to prevent), I didn't equate this with negative thinking. I was just being honest. My criticisms were valid. I had made too many mistakes."*



as a burden to others. For some people, this questioning the right to exist stems from early life experiences where the individual may have perceived their very existence as a burden to others. These individuals typically feel it would be so nice not to have needs (not to be needy), as this would spare them from the task of having to ask for help. If one does not have needs, one would not be a burden to others.

This perception can lead to questioning the whole issue of the right to exist. If we go down this thinking path, it is logical we will think of death as an exit, as an end of suffering, and as an end of being a "burden to others," another significant risk for suicide.

### Learned Helplessness

Some experience depression as an outcome that is a result of trying without success. If our thinking is so negative and so self-critical that we firmly connect with/and are convinced that trying does not lead to a positive outcome, what is the use of making any sort of effort? In this state, it appears simpler and easier to give up.

Some people have been conditioned, lifelong, to think this way and have experienced multiple "failures" leading to questioning if effort is of any use. If trying does not lead to any positive outcome, why try? This is the psychology of the depressed person, the socially-learned helplessness.

### Healthy/Unhealthy Depression

There are clinicians who talk and write about "healthy" depression; defined as realistic feelings of pain, sadness and disappointment as a response to traumas, losses, unfairness, or unresolved past damages. In this kind of depression, some people connect with their anger, which can be very productive in taking positive steps for the future.

This is different from the "unhealthy" depression which is much more of a functional issue; inability to function in almost all areas of life including failures at work and in relationships, and internalizing "I am stupid," or "I am a failure." This mental frame leads to a state of hopelessness and despair.

### Treatment

A thorough assessment will indicate the course of therapy. In my clinical practice, I find it very important to define the type of depression the client is experiencing, the cultural background influencing the individual, and the personal experiences that led to the depression.

When the depression is a cycle like in a bipolar type of depression, mood stabilizer medication can be quite successful. There are types of depression that are loaded in genetics, and it appears that medication is once again very helpful for these types of depression. When depression is a mixture of biology, with roots in psychology

(meaning the individual has been conditioned to be self-critical/negative, is experiencing feelings of uselessness or guilt, and is constantly questioning the right to exist), psychotherapy becomes an essential component of treatment. However, psychotherapy and corrective talk therapy alone are frequently not sufficient to disengage the mind of the depressed person. The depressed individual must also engage in daily structure and activity to free the mind from constant negative, critical and relentless chatter.

Depression is a very personal experience affecting different people differently.

## CHILDREN/TEENS

—Jan Schubert, LCSW  
Child, Adolescent, Family Services  
Coordinator, Teen Depression Program

Children are not immune to depression; roughly 5% experience a significant depression during childhood or adolescence. Ongoing stress, loss, attentional, learning, or conduct disorders influence the risk of depression.

Recognizing the symptoms of childhood depression can be difficult. Although some children experience classic symptoms (sadness, social withdrawal, anxiety, difficulty with attention, sleeping or eating problems), others express their depression through physical problems (headaches, stomach aches, various pains, etc.), or through increased irritability, aggression, hyperactivity, or misbehavior. To add to the confusion, all children pass through developmental stages so it is not uncommon to see 'normal' periods of negativism and rebellious behavior, along with temporary depressed states. In fact, in younger children, regression to earlier developmental stages such as wetting, soiling, or clinging may be indicators.

Careful observation (lasting weeks) is required before making an accurate diagnosis of childhood depression. To rule out physical health concerns or illness, a consultation with a primary health care physician is a good first step. A mental health professional, who specializes in the treatment of children,

can also help in the initial assessment.

Depression may be even more difficult to recognize in an adolescent. Feelings of sadness, loneliness, and anxiety associated with depression may be perceived as the normal, emotional stresses of growing up. Teens may describe themselves as "always bored" or "feeling nothing" rather than as depressed. Some express their depression through inappropriate anger or aggression, by running away, becoming sexually promiscuous, or through delinquent behavior. These teens may also 'self medicate' through alcohol or other drug use. Such behaviors, too often dismissed as typical adolescent behavior, are possible signs of depression and may be the teen's way of asking for help.

The clue to a depressive disorder in an adolescent is persistent signs of change or withdrawal from previous behaviors. Is the teen no longer meeting with friends or has she/he grown antisocial? Are grades slipping, or is the student beginning to skip classes? Has the use of alcohol/drugs entered the teen's world?

As with younger children, careful and prolonged observation is essential to separate 'normal emotional stresses' from depression.

## ELDERS

—Pat Anderson, LCSW  
Mobile Outreach to Seniors, Assoc. Manager

Depression in later life is common, though not a normal part of aging. Just as with younger groups, one in five elders is affected by depression. Older men with untreated depression have the highest rate of suicide, contributing to older adults having the overall highest rate of suicide of all age groups.

Depression in the elderly is associated with a wide variety of changes and losses – the loss of loved ones,

social and financial status, etc. Other contributing risks include medical decline, changes in metabolism or cognitive ability, along with increased use of medications and/or alcohol. A personal or family history of depression converge with loss, change, or fear to make depression more likely to occur.

Depression in the elderly, although common, is not always straightforward and is often difficult to recognize. As a result, it is often missed or misdiagnosed, and undertreated. In addition, many elders are unfamiliar with the signs of depression and see it as a lack of motivation or as a moral shortcoming rather than low mood, especially when it is not clear that there is a "legitimate reason to be sad." Some elders feel depression is a normal part of aging and/or nothing can or should be done about it. Others feel treatment is stigmatizing or too costly.

Clinically, the elderly (versus younger groups) most notably present depression to their physician in the form of physical complaints such as increased pain. In fact, depression commonly occurs along with a medical illness, making the medical illness/disability worse, with more frequent clinic visits and

*Untreated Depression is disabling in all aspects of life.*

- **Mood**  
persistent sadness or despair, inability to enjoy activities, irritability
- **Physical**  
vague aches & pains, decreased appetite, insomnia or sleeping too much, feeling slowed down or agitated
- **Thinking**  
difficulty with decisions, memory, thoughts of helplessness, guilt, hopelessness, suicide
- **Social**  
isolation, apathy, poor motivation





*"What frightened me the most was that I couldn't see the 'light at the end of the tunnel.' I didn't know where my sadness was taking me."*

longer hospitalizations. Fortunately, antidepressants help with both depression and illnesses, such as chronic pain.

Elders benefit from the same things (medication, counseling, etc.) that help people in other age groups to recover. Since depressive episodes often recur, it is important to treat depression with long-term management. This includes elders and caregivers learning to identify early signs of depression and to seek treatment as soon as possible. The recognition and effective treatment of later life depression leads to great optimism that later life will be more healthy and meaningful for both elders and those who care about and for them.

## **CULTURAL INFLUENCES**

— Dr. Xia Xavier Xiong  
Mobile Outreach to Seniors Team

Among Southeast Asian refugees, depression is a silent epidemic and a major stigmatized condition, especially with the elderly. In the past decades, the word depression is literally translated into Hmong as "nyuaj siab" which is considered a norm, usually preceded by a life event and requiring no medical or psychological intervention. Most of the Southeast Asian community still believe that once the event has passed, and a person has a healing ceremony, depression or "nyuaj siab" will no longer exist.

Mental health treatment is somewhat new to the Southeast Asian community, and the individual risks being labeled as "crazy" if he/she seeks to be treated for a "mental dysfunction" such as depression. These misconceptions have brought much resistance to seeking medical or psychological intervention.

The language barrier is another reason that depression may be overlooked and left untreated among the Southeast Asian community. The individual might be suffering from

psychological trauma but his/her symptoms may manifest physically such as headaches, fatigue, neck and low back pain, and abdominal distress. This hinders recognizing the psychological nature of the complaint and might lead to misdiagnosis or mistreatment medically.

In order to optimize the improvement of intervention for depression among the Southeast Asian community, public education, awareness, early detection, and treatment implementation must be disseminated in a culturally and linguistically sensitive manner. In addition, a professional translator, who is also a cultural interpreter, may be the best way to provide communication with western care providers.

## **GENDER DIFFERENCES**

Twice as many women report experiencing depression as men. From the perspective of Dr. Ellen Leibenluft, Chief of the Unit on Affective Disorders at the National Institute of Mental Health, "Men are not more likely to deny symptoms, rather, they are more likely to minimize or forget past episodes. This, however, cannot account for the gender differences in the prevalence of depression."

"Men and women report similarities in degree of impairment, length of episodes, chronicity of the illness, time to first recurrence, or number of recurrences, but women are much more likely to report seven or eight symptoms of depression. And pure depression — in which the person has no other psychiatric illness — is more common in women. In cases when depression is secondary, following another illness, in women it often follows anxiety disorders, while in men it often follows substance abuse disorders or conduct disorders. Women are more likely to develop substance abuse disorders after they become depressed."

## **What Helps**

Once identified, depression is treatable. In addition, individuals and families can support their own recovery through the following:

- Talk to individuals/families who experience depression; join support groups; share useful information.
- Be informed, obtain accurate information from libraries, associations, web sites, hotlines, or other reliable sources.
- Ask questions about your treatment and services.
- Set realistic goals in light of the depression. Break large tasks into small ones, set priorities, and do what you can as you are able.
- Try to be with people whom you feel comfortable with and whom you can confide in; it is usually better than being alone. Let your family and friends help you.
- Regular, on-going exercise (running, walking, biking, swimming, etc.) seems to increase the body's endorphins and can lift one's spirits.
- Participate in activities to help establish structure and purpose, especially ones that may make you feel better.
- Many people find mind, breath, body activity (meditation, yoga, t'ai chi, self-hypnosis, massage, etc.) useful to the balancing of energy and the return of natural sleep.
- Many people look to their spiritual or religious practice for support and guidance.
- Limit the use of alcohol or other nonprescription medication/drugs.
- Expect your mood to improve gradually, not immediately. Feeling better takes time.

## Useful Websites

- American Academy of Child & Adolescent Psychiatry  
Facts for Families (English/Español)  
[www.aacap.org/publications/factsfam/index.htm](http://www.aacap.org/publications/factsfam/index.htm)
- National Institute of Mental Health  
Fact sheets in English  
[www.nimh.nih.gov/publicat/index.cfm](http://www.nimh.nih.gov/publicat/index.cfm)
- National Institute of Mental Health  
Información en Español  
[www.nimh.nih.gov/publicat/spanishpub.cfm](http://www.nimh.nih.gov/publicat/spanishpub.cfm)
- NAMI (National Alliance for the Mentally Ill)  
English/Español fact sheets  
[www.nami.org/illness/](http://www.nami.org/illness/)

## Mental Health Center

The mission of the Mental Health Center of Dane County, Inc. is to provide individuals and families with high quality, community based and recovery oriented mental health, substance abuse, and advocacy services that respect cultural differences and foster hope, strength, and self determination. We will give priority to individuals and families with high needs and low resources.

Children, teens, adults, seniors, and families have received MHDCDC services for 55 years. With nine agency locations and outreach to community sites (homes, schools, workplaces, senior center, etc), the MHC is one of Dane County's largest community nonprofit agencies.

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## Newsletter

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*"The only way I can describe my depression is to say it is an incredible personal assault. I knew depression could leave people feeling devastated and overwhelmed, but I wasn't prepared for how much it would attack my ego and shatter my self esteem. Nor did I anticipate how much I would fight a diagnosis."*