

Dr. Tony Bates in conversation with Thérèse Gaynor

Tony: So Thérèse, talk to me or lead me into this gently.

Thérèse: First of all, thank you for taking this time to meet. My interest in hearing more about the work you are involved in and in particular your views on depression and suicide comes primarily from hearing you speak at the conference on Turning the Tide on Suicide. You spoke about; *Conversations That Keep Us Alive* and this has remained with me. It touched a deep part of me and has impacted both personally and professionally in how I consider depression and suicide now.

Tony: Well I like to think that depression is the first noble truth. It is one of the most fundamental experiences of all human beings that we feel depressed; we often feel the loss of things that are important to us and that don't work out for us. This can leave us feeling very down and hurt. All of us, I think, know in our bones the experience of loss and depression.

I think depression is centrally about loss and grieving that loss and sometimes, it's a very necessary loss. You know the loss of illusions, the loss of a sense of omnipotence, the loss of arrogance, of perfectionism. These are all losses that everybody experiences and I think it's really important to talk about depression as something that's part of the human condition.

We talk about clinical depression and what distinguishes clinical depression is the intensity and the duration of that experience. It seems to drag on forever and it can be very disabling. If you read a book like William Styron - *Darkness Visible: a Memoir of Madness*, in which he describes the subjective experience of being clinically depressed – and there's no doubt when you read it, that there's a kind of qualitative difference about the experience that is – it's way more than just a bad day - it's terribly physically and psychologically painful. I think there are some people who have this very disabling, severe experience of depression. Now whether there are as many as the five percent that we say at any one point in time are clinically depressed in this country or ten percent in the course of a year, I don't know. I think a lot of what gets categorised under clinical depression probably reflects more the normative experiences of loss and grief that are painful and troublesome for people.

Thérèse: It would seem that to consider the possibility that depression is both an individual and a universal response to unprocessed loss and grief, is to normalise it in some way as part of the human condition.

Tony: Depression is never that far away and in the people I see in St. James' Hospital or in the course of my work as a psychologist, I see something of the qualitative difference, but I don't see their experiences as being caused by factors other than those that provoke normal depression. I think their way of trying to process these experiences becomes complicated, stuck in different ways.

People prone to bouts of deep depression can be set off by very minor upsets, which trigger intense reactions and make little sense to them. When you look at their lives it's very often some significant loss that they haven't processed. The root of their depression is unprocessed pain and an abiding negative bias in their thinking about themselves. Their depression is compounded by being depressed about being depressed.

For the past five years, the incidence of diagnosed depression has increased and with this increase there has been a parallel rise in the prescription of anti-depressants. So you could say, depending on what side of the fence you're on, that more anti-depressants are prescribed annually for the last five years, because every year there's more depression. Of course, you could equally say that more human suffering has been categorised as clinical depression over the past five years, because there's a very easy availability of SSRI's, and it becomes a convenient diagnosis into which you can lump a lot of psychological distress. It's interesting to note that the rate of diagnosis of what were termed 'neurotic disorders' has decreased in parallel with the apparent rise of clinical depression.

Thérèse: In considering what you're saying regarding the subjective experience of loss and grief, I'm wondering about depression as a manifestation of repressed feelings in individuals and how this sits therapeutically, in particular with the psychoanalytic position that depression is anger turned in on itself?

Tony: Well that was Freud's position on depression, which he called melancholia, the notion of the person turning feelings inward against themselves - very often to try and repress angry 'unacceptable' impulses they felt as part of the experience of grief. Rather than admit negative

feelings towards a loved one, they turn those feelings against themselves. I think we have since learned to appreciate that repressed anger is only one of a number of possible triggers for depression that a lot of people also become depressed through abandonment, helplessness and a loss of self regard for themselves.

I think that the experience of depression can also emerge out of a conflict; out of a sense of protracted stress where people feel trapped, with no possibility of escape. There can be a sense of just being frozen in time and not being able to change things, and if this is protracted over time, an imploding and giving up can happen.

I think the challenge therapeutically in working with depression is to reconnect people with their own vitality. Sometimes that comes through crying and some times it comes from being angry and some times it comes through re-discovering a sense of self in conversation with another. I asked two service users from St James's what they thought was most fundamental in causing depression and they both agreed that for them, it's the loss of honest, real, emotional communication.

Conversations that keep us alive are about trying to restore the possibility of very honest emotional communication. You know, looking someone in the eye and saying; *how are you?* and really wanting to hear their response. Maybe we've lost that natural facility or the normal structures that were there in community that allowed that to happen, be it in a bar or after mass or during a match – maybe we've lost some of that. We're all talking a lot of the time, but perhaps it's not very often in the context of genuine nurturing communication.

Conversations that keep us alive are the conversations that ground us, help us to feel attached and create a safe holding place to contain our pain as we examine it, unravel it, understand it and to see its different elements, and what we need to do to move forward.

Thérèse: It seem to me that you're talking very much about things that are integral to therapy, the therapeutic relationship and the person's resources and developing these resources.

Tony: Yes, I'm interested in what helps recovery. In looking to what's right with people than what's wrong with people, on the strengths that we can build on and recruit to help those parts of themselves that are floundering. I do think that there is healing in presence and the discipline of therapy for me is that discipline of being present. Being very present with people, with all my faculties; my mind, my heart, my instinct, my intuitions. Truth often emerges within the energy field of vital present moment communication.

I think it's really exciting to be open to those un-expected leads that come in a conversation so you can follow them and track them and then gradually begin to make sense of them. For so many people who are depressed there is such relief in being able to make sense of what they consider to be stupid or weak. There is a great relief and liberation in being able to see the reasons why you feel so troubled. You can release a lot of energy through acting out or through some controlled catharsis, but at some point it's got to make sense to you so you can learn to take care of what's hurting and relate to yourself and your own vulnerabilities with a degree of kindness and hard-headedness.

I have had my own baggage to work through in life, and for a while, several years in fact, I worked at it through gestalt therapy. Lots of dramatic expressive working out of emotions, which was wonderful. But I fell badly into a depression some years later and had to start exploring where all this was emanating from. I had a few hunches and was fortunate to find a great family therapist in the States, where I spent seven years, who identified at least some of the knots in my psyche and helped me to unravel them. It involved assembling family members and clearing the air on a number of matters and that was also critical for me, and them.

When I was in a particularly dark patch, which lasted a number of years, I considered medication. I chose not to take anti-depressants because I felt that I had enough resources in myself and around me to take me through, and I had a pretty good hunch where it was all coming from. So, for me, I sensed that this was an emotional crisis that was important for me to deal with psychologically. It was painful, but also an invitation to develop a deeper self-understanding and compassion towards myself.

I think possibly the whole process of recovery, in terms of my general mood, was slower because of my personal choice to do it without medication. But I always think genuine healing really does take time, and the self-understanding you achieve gradually through therapy becomes a very important protection against slipping back into one's black holes. I

don't judge anyone who takes medication. For some it can be an important component of recovering energy and sleep, without which you can't function at all. I have seen many people who took medication alongside therapy and it allowed them to get engaged and work at issues in their life.

Thérèse: The issue of medication is important to consider when we are continuing to meet with so many people coming for therapy who are on anti-depressants or anti-psychotic drugs?

Tony: The issue about medication is that there is an element of choice that needs to be honoured in people because there is no doubt that there are times when someone can feel too overwhelmed by their pain. In saying this, I am not subscribing to the notion that depression is located or triggered exclusively by some very particular fault in brain functioning. There are deficits in the way the brain works when someone is deeply depressed and sometimes reactions undoubtedly get triggered and follow well worn neural pathways that produce symptoms of depression. There is a physical aspect to feeling bad for all of us. There are parallel changes in the body and in the mind and in our social behaviour, all of which constitute depression and all of which need attention. But when you medicalise depression completely and put it down to some disease process, you disempower the person and only buy them very temporary relief, if indeed you even do that.

If medication is the only intervention, you are just buying time. If you stop medication, there is an almost certainty that you will relapse and fall into an even deeper conviction that there is something permanently wrong with you. One problem with medication is the implied message carried so often in the writing of a prescription: that there is something internal, chronic and regrettable wrong with you, rather than that there is something wrong in your life – both your inner and outer world - that requires your attention and which can be healed with time and skill.

The big problem is that for many people, depression is a relapsing recurrent condition, with the risk of relapse rising the more you fall into deep depression. That's what got me interested in mindfulness-based cognitive therapy, which is a proven method of reducing relapse among people who had recurrent depression, by a factor of 40%. The mindfulness course we've been running in St James's incorporates meditation, yoga, chi gong and simple cognitive therapy strategies.

It uses the breath as an anchor and teaches someone to be still and allow difficult material to arise in their awareness, without judging it or without

pushing it away or before someone becomes all wrapped up in the narrative that generally accompanies painful affect. It gives them a platform from where they can safely view their experience and a sense of identity that is not defined by their negative thoughts or feelings.

In the current group in St James, there are twelve people who've had well over one hundred admissions between them to mental hospitals and acute inpatient facilities. Admission to the course requires that they are not in an acute episode of severe depression. Our mindfulness course is all about learning to stay well and take care of yourself, once you've re-emerged from the acute hell of a depressive episode. Since beginning mindfulness and practicing it regularly, the group members have had hard times, but they have remained psychologically very well, and not required re-admission to hospital.

Mindfulness is a very ancient practice and we've not added to it or changed it. We've simply developed a very simple step by step methodology as to how one can learn this practice. Starting very simply with the breath and just breathing and being present with oneself. Very often people might do that for three minutes a day to begin with, and that's fine. We also do various movement exercises which are wonderful for bringing people back into connection with their bodies.

We meet, we stretch, and we sit quietly with ourselves and enjoy our breathing. It's not some kind of esoteric Zen activity that is bringing people out of body or out of the real world. It's about breathing and being present in the moment of what ever is going on for oneself. It's about finding a freedom to be in your experience whatever that happens to be, rather than trying to flee from difficult experiences. Mindfulness is about being present to what is most real in any given moment of our lives, but it teaches people a way of being present and steadying themselves, in the face of painful inner experiences that have previously triggered them into a depressive episode.

Thérèse: I'm curious about what you might consider an appropriate therapeutic approach when meeting with a person experiencing severe depression?

Tony: It's funny, I think that this is where therapy has to come back to being very person centred and though it's very difficult to make generalisations, I think that for people who are very severely depressed the initial focus needs to be on helping them become active and engage with very basic elements in their lives, which they may be avoiding, out of terror.

The principle that ‘activation precedes motivation’ can be very helpful to someone who feels physically immobilised. The simple message that to do something, regardless of how you feel, produces a release of the energy you need for that task. So, for example, I wake up in the morning, I do not feel like getting out of bed but when I get out of bed I feel much happier that I’m up. And that’s often within a matter of seconds. If I’m waiting for the feeling of wanting to get out of bed to arise in me, I’ll be waiting a long time!

Setting manageable goals is also very important for someone in severe depression; depressed people can be very unrealistic about what is achievable for them. Dealing with the stresses that are immediately around you – pay that bill, make that phone call, talk to that person – can give someone back a sense of control and mastery over their environment and restore one’s morale and well-being.

The research is very interesting around the reoccurrence of depression. They have looked at why it is that people who have had experiences of depression seem more susceptible to getting upset in response to minor events. They’ve done very interesting studies – they’ve taken people with no history of depression and people with a history of depression and they’ve taken them in group form into a room, into a laboratory. And in this setting they’ve played a certain Prokofiev piece, a slow funereal piece of music, or had them read words that are associated with negative events and feelings. Someone who hasn’t had the experience of severe episodes of depression may experience sadness in response to these stimuli, but they recover pretty quickly. The depressed group, those with a history of severe depression, have a very different reaction; what happens is that the stimuli trigger very negative feelings and ruminations which seem to cascade and pull them downwards into the spiral of depression. So, even when the experiment is over, their depression is not over, it’s all happening once more for them.

So we know that depressed people are more vulnerable to being upset, than other people who get upset in different ways, becoming angry, or anxious. The next question is, what happens that they fall foul of this, why do they keep falling into the hole. Well, curiously it turns out that when they have these experiences they try to help themselves, they start to think positively and say things like, “don’t be going there – this is ridiculous”, “I shouldn’t be feeling this, this is nonsense”. They ruminate in an attempt to push away the experience or to claim for themselves the right to feel good and they get into battle with themselves. They have no other way to process their experience, other than fighting with themselves, but tragically the more they do this, the deeper they dig themselves into the very hole from which they

are trying desperately to escape.

Part of the mindfulness training is about how to engage with the experience, how to accept and allow the experience to be present without being drawn into these ruminative patterns and reactions.

Thérèse: I'm wondering how the practice of mindfulness you are describing fits in a mental health system where a person experiencing depression may not be offered or have an opportunity to engage in a therapeutic process?

Tony: Mindfulness is not a substitute for psychotherapy. There is a time for therapy that offers a one-to-one encounter and there's a time for group and there's a time for medication for some or whatever avenue of healing people choose to go down. And then there's a time, after you've gotten enough understanding of yourself and what's been happening, to develop a different kind of relationship with yourself and practice learning to take care of your vulnerabilities in a skilful way. I think mindfulness training is very good for that.

The problem for many humans is that we are so "pain avoidant" that we turn away from our difficult feelings. While this may work momentarily, the escape we buy is always a return ticket. Learning to relate in a different way to suffering, without pushing it away or trying even to "fix it", is how we find inner freedom. I really like a quote I read by Malidoma Patrice Somé which says that "the person in pain is being communicated to by a part of themselves that has no other way of speaking"

I'm working with the Mental Health Expert Group, a group that has been asked to write a report on A Framework for Service Provision for Mental Health right across the lifespan. It's trying to say how we should do things to build a greater appreciation for what psychological wellness is really about, and to be there for those who struggle with serious emotional problems and need some specialist help. It's another kind of challenge for me, trying to evolve a different vision of how things can be, towards a more person-centred and recovery-oriented philosophy of care.

The model we are proposing depends entirely on building partnership with service users and their carers and with each other as professionals. It will propose a more community-based service because people's lives are lived in the context of their relationships with others and with their work, within their own community. It will be considering in some detail how we can

work as multidisciplinary teams and involve service users in every aspect of service provision and planning. In our consultations with service users and providers, we have heard from them that they want more ‘talk therapies’, they want a range of psychological interventions that can address their needs and objectives. I can see a mental health service unfolding in the coming years where these interventions will become central and widely available. But it will take a little time.

Our mental health services have been quite dominated by a ‘medicalised’ model of care for some time. We need to embrace a much more radical holistic way of thinking about people and suffering. That’s what we’re trying to move towards in this report. And to operationalise this philosophy in certain structures that make that reality and not just an ideological dream.

Dr Tony Bates is Principal Clinical Psychologist in St James’s Hospital and Course Director of the MSc Cognitive Psychotherapy, Trinity College Dublin.

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