DEPRESSION:

"a shimmer of not-thereness"

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By Kimberly Storr

INTRODUCTION

In "One Cheer For Melancholy" Susanna Kaysen discusses the modern American paradigm and its influence on our perception of depression. She fights the attitude that "sadness is bad and must be eliminated"[1] and says Americans are "saddled with the idea that we can and should be happy."[2] She joins the ranks of many artists, writers, philosophers, and doctors who have argued over time that there is an inextricable link between melancholy and creativity, and that only through experiencing the depths of despair do people truly value and understand happiness. Besides, she says, "…depression and despair are reasonable reactions to the nature of life. Life has its ups and downs. It is unreliable and conditional and provisional….Is it any surprise if some of the time, some of us feel like hell?"[3]

Kaysen is not trying to glamorize depression, just normalize it. Part of what is wrong with being depressed, she points out, is the perception that depression is *wrong*. In of a long list of items our society seems to have collectively deemed too uncomfortable to discuss, depression joins issues like death as functionally taboo. According to Kaysen, it is a reflection of death specifically that makes depression so difficult for many people to deal with.

> "The worst thing about depression—the thing that makes people phobic about it—is that it's a foretaste of death. It's a trip to the country of nothingness. Reality loses its substance and becomes ghostly, transparent, unbelievable….depressed people feel they aren't 'there.'
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> …When I'm feeling good I sometimes think of feeling depressed, the sliminess of it, when what I see has a shimmer of not-thereness and what I feel has a slippery way of falling off after a minute, so that I can't sustain the sensation of being alive."[4]

In a society that tends to euphemize most of life's complexities, referring to dying as "passing," to bombing as "air support," and to unplanned pregnancies as "accidents," it's no wonder that a real dialogue about depression is lacking. When addressing depression through massage it is important to understand the greater social attitude toward mental health in this country, and the ways in which fear-based marginalization of people outside the "norm" can manifest as an added burden of any mental "disorder." This may mean that many stigmatized clients will not verbally disclose their emotional struggles at all, but it is imperative that they are met with a safe and truly accepting space, where it is okay to feel sad, slimy, and not-there.

DEFINITION & DEMOGRAPHICS

Depression, just as the name suggests, leaves a person feeling low, like the world is pushing in on them—so much so that it can become overwhelming. Symptoms arise as unique fusions in

[1] Susanna Kaysen, "One Cheer for Melancholy," in *Unholy Ghost: Writers on Depression*, ed. Nell Casey (New York: Harper Collins, 2001) 42.

[2] Ibid., 41.

[3] Ibid., 43.

[4] Ibid.

each person, but amount in most people to what Hemingway called a "terrible mood," and often include a sinister trio: feelings of hopelessness, worthlessness, and restlessness. In Major Depressive Disorder (MDD) these and other feelings can completely disable a person, as they did Hemingway, interfering with their ability to sleep, eat, and enjoy themselves at all. Unfortunately, major depression is rarely a one-time visitor, and Major Depressive Episodes (MDE's) usually recur more than once in a person's lifetime. In other people, depression presents more mildly but lasts for at least two years. This is called Dysthymic Disorder, or dysthymia, and while it may not be as debilitating as MDD, dysthymia certainly interferes with "normal" functioning. Other forms of depression include Postpartum Depression, which up to 15% of women experience within one month of delivery. This can be a devastating illness, with lasting effects of guilt due to mothers' perceptions of how a lack of bonding with their baby will affect that child later. In some climates, Seasonal Affective Disorder (SAD), due to a wintertime lack of sunlight, can be the cause of very severe depressive symptoms.

Depression very often co-exists with other conditions and, "the mechanics behind the intersection of depression and other illnesses differ for each person and situation."[5] It is not surprising that people suffering from life-altering or life-threatening diseases, such as heart disease, chronic fatigue syndrome, HIV, and Parkinson's often develop significant depression. Not only are they suffering physically, but very often they are also combating social stigma and/or the emotional burden of leaving loved ones behind. These same stressors often face substance abusers as well, and there is a high prevalence of depression among this population. In many cases, addicts point to long-standing depressive symptoms as their motivation for abuse in the first place. Other conditions that are regularly comorbid with depression include most other psychiatric disorders, especially post-traumatic stress disorder, obsessive compulsive disorder, panic disorder, and generalized anxiety disorder. In fact, anxiety so often co-exists with depression that a US Surgeon General's report claims that "patients with combinations of anxiety and depression are the rule rather than the exception."[6]

Women experience higher rates of depression than men do, with nearly twice the rate of incidence at certain age levels. This is due to many factors, of course, including women's greater tendency to internalize stress. In adults (18 and older), 14% of the population reports experiencing a depressive episode in the last year, with 11% of men and 17% of women affected. Looking more closely at the numbers, it is clear that after age 50 the risk of depression takes a dip for both males and females, but for women between 18 and 50 incidence is nearly 20%. In other words, one in five women in that age group has suffered a major depressive episode in the last year. In young adults (12-17) the seeds of this trend are evident, as nearly one quarter of girls 15 to 17 years old report depression. Because depression is highly linked with childhood sexual abuse, which females experience in greater numbers, these percentages may somewhat speak to this reality. For youth of both genders, the risk of a depressive episode rises with each birthday. The overall rate for this age group is 13%, but incidence jumps from 6% for 12 year olds to 17% for 17 year olds. Interestingly, both mixed-race adults and youth

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[5] National Institute of Mental Health, *Depression* (2007), US Department of Health and Human Services, 5.

[6] Mental Health: A Report of the Surgeon General, "Etiology of Mood Disorders,"Office of the Surgeon General, http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec3_1.html (accessed February 26, 2008).

appear to be at highest risk for depression out of all race categories, with a nearly 20% incidence at all ages.[7]

Depression, like few other conditions, has significant psychosocial components. For instance, studies suggest that the "combination of life stress and inadequate social support contributes to women's great susceptibility."[8] Women, still, confront inequalities in the workplace that hinder economic freedoms, and often, still, feel they are expected to maintain a shipshape home, work a full-time job, and stay physically fit, to boot. The fact that people with "some college" report among the highest incidence of depressive episodes may reflect "middle class gap" frustrations felt by many people when their upward mobility is mired by their lack of a higher degree. This education dynamic appears to be most significant for females, and may echo the struggle of many women to reconcile academic and career sacrifices with the demands of motherhood. For men, it is clear that the social construct which "requires" they be breadwinners plays an enormous role in depression. Incidence of MDE's is five percentage points higher among men in the lowest income bracket, a factor that seems to play little role for women. Across the board the highest rates of depression are reported by people who are divorced or separated. While the stresses of ending a relationship would be anticipated to have such an effect, people who have *never* been married also have higher incidence of depression, suggesting that there is a healthy emotional byproduct of being in a successful partnership.

ETIOLOGY & SYMPTOMS

Depression is cloaked by a number of unknowns. As made clear from the statistics above, varying external factors—be they psychosocial, traumatic, or environmental—may trigger depressive episodes in people, but any given individual may or may not perceive these same events as depressing. The role of internal factors remains somewhat of a mystery, and depression is vaguely described as resulting from a combination of genetic, biochemical, and psychological elements. The fact that one in seven women experience postpartum depression seems to indicate a possible hormonal cause, but this is nearly impossible to isolate considering the immense changes that occur, beyond the hormonal, when a woman gives birth. While Western treatment approaches have focused on "imbalances" of neurotransmitters, whether these chemical disparities are the cause or result of depression remains uncertain. Adding to this complicated equation is the fact that MRI results for people with MDD show structural differences deep in their frontal and temporal lobes, including the hippocampus and mood regulating areas. Again, whether this is the proverbial chicken or egg of the condition is unclear.

A genetic link seems to be real in depression, though many people with no heredity factor experience depression just as severely as those that do. Some theories point to the methods a person uses to mediate stress, as opposed to the stressful events themselves, as a significant dynamic in the development of depression. These self-management habits, usually developed

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[7] US Department of Health and Human Services, Office of Applied Studies, "Mental Health - Tables 6.1 to 6.41 (Prevalence Estimates for 2006)," SAMHSA, http://www.oas.samhsa.gov/NSDUH/2k6NSDUH/tabs/LOTSect6pe.htm#top (accessed February 29, 2008).

[8] Report of the Surgeon General

out of environmental influences in youth, may be part of the reason a genetic link exists, as some families tend overall to deal poorly with stress. Further, certain temperaments, generally associated with deficient coping, have been found to be highly associated with depression and other mood disorders. People who tend toward avoidance, dependence, reactivity, and impulsivity are likely to not only deal ineffectively with personal stress but are also more likely to provoke confrontation, potentially adding to their own feelings of guilt, frustration, marginalization, and isolation.

Regardless of why depression occurs in any individual, these varying elements combine to create an observable altered state, though if changes are subtle it may take an intentful eye to see them. Among the most common symptoms are: persistent feelings of sadness or emptiness; anxiety; hopelessness, worthlessness, and restlessness; irritability, pessimism, and guilt; loss of interest in previously enjoyable activities, including sex; fatigue and low energy; difficulty with concentration, decision-making, and memory; insomnia or oversleeping; over- or under-eating and/or significant weight change; suicidal thoughts or attempts; and unrelenting aches, pains, headaches, cramps, and digestive disturbances, none of which respond to treatment. For men and women, the manifestation of these symptoms can be very different. Men, who tend to externalize stress, are more liable to recognize and admit symptoms of fatigue, irritability, loss of interest (especially in sex), and sleep disturbances. They are also more apt to react to these symptoms with behaviors of excess, including alcohol and drug abuse, overworking, and risky or reckless decision-making. Women, on the other hand, are more likely to acknowledge feelings of sadness, worthlessness, and guilt, and may place significant blame upon themselves for not being able to "snap out of it."

WESTERN MEDICAL TREATMENT APPROACHES

Western approaches to the medical treatment of depression, as mentioned above, have concentrated on pharmacologically effecting neurotransmitters associated with mood, specifically serotonin, norepinephrine, and sometimes dopamine. While it is generally agreed upon that these chemicals do in fact regulate mood, just how they do so is still unknown. Thus, when people are medicated for depression, usually with drugs that effect re-uptake of neurotransmitters, there is little accounting for an individual's own chemical homeostasis. Titrations of dosage are applied with a guess and check philosophy motivated by one central assumption—that the feelings related to depression must be artificially eliminated—which adds to the prevailing mainstream perception that feeling depressed is wrong.

Despite the fact that the anti-depressant industry is a multi-billion dollar a year enterprise, and these medications are prescribed freely, ultimately their mechanism in the brain is not completely understood. Drugs meant to effect serotonin re-uptake, known as SSRI's, include Prozac, Celexa, and Zoloft. Those intended to alter norepinephrine levels, SNRI's, include Effexor and Cymbalta. Side-effects of these medications tend to be milder than those associated with older classes of anti-depressants, such as tricyclics and MAOI's, and consist of headaches and nausea (usually only temporarily at the start of use), insomnia, agitation, and sexual difficulties. However, some older drugs, especially tricyclics, are still used for people who don't respond to SSRI's and SNRI's, and include side-effects as extreme as blurred vision. And, though

not listed, technically, as a side-effect, many people anecdotally report feelings of emotional numbness, or dumbing-down. For some, especially those in creative endeavors, this side-effect is a deal-breaker, leading many to struggle with issues of functionality versus self-identity. Numerous essays and other ruminations by writers who deal with depression address this conundrum of anti-depressants specifically.

The fact that so many people take anti-depressants with regularity, despite their side-effects, is a sign of the considerable changes in social tendencies that have grown since the post-war period of the 1950s when Dexamyl, a stimulant/sedative mix, was introduced to help unfulfilled and unsatisfied housewives deal with their "nerves," and became known as "mother's little helper."[9] Not surprisingly, this coincided with the rise of pharmaceutical companies, which got their start following synthetic drug breakthroughs spurred by WWII field medicine research. Dexamyl and similar drugs were eventually found to be highly addictive and rife with unpleasant side-effects, but not before an explosion of sedatives and tranquilizers on the market, many available over the counter. Though critics questioned "the appropriateness of tranquilizing on such a large scale," a culture of legal drug use was born.

In *Let Them Eat Prozac*, former drug researcher and one-time SSRI proponent, David Healy, who considered depression *under*diagnosed in the 1980's and early 1990's, argues that logarithmic increases in diagnosis of depression—to the point of significant *over*diagnosis—are artificially motivated by "Big Business" and "Big Science." The "Big," of course, a result of massive infusions of money into these industries in the last twenty years, accompanied by powerful PR strategies and calculated attempts to make depression a household name. As an industry insider for many years, Healy was a critical witness in Congressional hearings held to determine whether Prozac use can lead to suicide, which he believes is likely, based on years of evidentiary findings. However, even regarding this devastating possibility, drug companies "blame[d] the disease, not the drug,"[10] a tactic that served only to further demoralize people suffering from depression.

A recent study has debunked many of the well-designed marketing messages aired by companies that produce anti-depressants. Researchers at the University of Hull, in England, have concluded that drugs such as Prozac and Effexor may have little clinical effect except in cases of "severe" major depression. They argue that data previously used to support the efficacy of these drugs does not properly discount the placebo effect, a phenomenon they reported in large numbers in their research. Professor Irving Kirsh, who led the study, asserts that, "'given these results, there seems little reason to prescribe anti-depressant medication to any but the most severely depressed patients, unless alternative treatments have failed.'"[11] Naturally, massage may promise to be among the most effective alternative treatments for depression.

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[9] David Healy, *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression* (New York: NYU Press, 2004) 4.

[10] Ibid., 175.

[11] BBC News, "Anti-depressants' 'little effect'" (February 26, 2008), BBC, http://news.bbc.co.uk/2/hi/health/7263494.stm (accessed February 26, 2008).

THE PHYSIOLOGICAL EFFECTS OF MASSAGE

In a healthy response to stress, the sympathetic nervous system initiates release of both adrenaline, to jumpstart cardiovascular and metabolic activity, and cortisol, to slow functions deemed unnecessary in a fight-or-flight response. When people are subjected to the high levels of long-term emotional stress associated with depression, they often fall into an unhealthy stress hormone cycle, wherein stress chemicals remain elevated despite no real threat. Cortisol, particularly, can be systemically disruptive when it is elevated over time, increasing a person's risk of obesity, digestive disorders, heart disease, and immune dysfunction.[12]

Fortunately, therapeutic massage lowers blood levels of numerous stress chemicals, including epinephrine, norepinephrine, and cortisol. Additionally, massage has been found to increase infection-fighting white blood cell counts. Researchers at the Touch Research Institute have also shown that massage effectively decreases depression and anxiety in patients with fibromyalgia, chronic fatigue syndrome, and post-traumatic stress disorder, as well as in youth psychiatric inpatients. In patients with anorexia and bulimia, massage offers these same benefits but can also improve body image, a tall order in today's image-conscious society.

Not only does massage have benefits in the short-term, but TRI research has revealed these positive effects are lasting. A study published in 1996 showed that depressed adolescent mothers who received regular massage for five weeks exhibited "behavioral and stress hormone changes including a decrease in anxious behavior, pulse, and salivary cortisol levels" immediately after their sessions. But what's more, tests conducted following this treatment period still indicated decreased cortisol levels. The significant emotional effects of massage, including transformations in self-awareness and self-empowerment, complement and support its physiological effects, and all these changes merge to become a very powerful tool for recovery. This was obvious in the times of ancient Greeks and Romans, who attributed a variety of mental variations, including depression, to either imbalances in "bodily humors" or to supernatural interventions. When the "humors" were to blame, the cure was physical, and included "…a balanced diet, massage, soothing music, and healthy living."[13]

BODYWORK AND HEALING APPROACHES

When working with people who suffer from depression, the greatest gifts a massage therapist can give are those of acceptance and intent. Helping a person to find unexpected calm can have remarkable impact. There is no specific modality more appropriate than another; it is simply a matter of finding each person's own path to stillness. Some techniques, such as body rocking and occipital holding, tend to be universally relaxing. As therapists, intent should be focused on

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[12] Mayo Clinic, "Stress: Unhealthy Response to the Pressures of Life" (September 12, 2006), Mayo Foundation for Medical Education and Research, http://www.mayoclinic.com/health/stress/SR00001 (accessed March 1, 2008).

[13] Cherie G. O'Boyle, *History of Psychology: A Cultural Perspective* (Mahwah, NJ: Lawrence Earlbaum Assoc., 2006) 191.

drawing a client away from anxiety and into a place of safety, on guiding the way to a deep parasympathetic state, and on accepting with understanding any emotions the client experiences. Beyond this, it is the details that can speak volumes—perhaps offering a therapy light to people dealing with SAD, or encouraging clients to bring along any music that makes them feel happy or content.

Aromatherapy

Sense memories of any kind can be very powerful, but only smell directly effects our limbic system, which is complexly intertwined with mood, memory, and emotion. By acquiring new, positive scent memories associated with massage, depressed people can often re-induce the positive feelings of that experience at a later time. Therefore, aromatherapy can be an invaluable part of massage for clients with depression. Citrus oils appear to have the strongest effect on depressed people—in one study most of the patients who inhaled a mixture of lemon, orange, and bergamot oils reduced their medication dosage to *zero* in eleven weeks. Perhaps equally important, and possibly behind their improvement, was the fact that their dopamine and cortisol levels dropped significantly over that time, a phenomenon that would not necessarily be anticipated as medication is reduced. It would seem, based on such results, that scent can physiologically effect the brain, and the study report concluded that, "'citrus fragrance may improve the homeostatic balance more than treatment with anti-depressants.'"[14]

Aromatherapy recommendations for depression, aside from citrus oils, are: basil, fennel, frankincense, geranium, marjoram, rose, and ylang ylang. For postpartum depression, basil and frankincense are not used, and grapefruit is specifically indicated. And, for depression associated with pre-menstrual syndrome, jasmine is particularly effective. Essential oils that reduce anxiety, known as anxiolytic, include basil, bergamot, cypress, lavender, marjoram, neroli, petigrain, and ylang ylang, so there is considerable cross-over.

Good formulas for concentrated massage oils to use on clients with mild and general depression follow. Concentrated oils are not meant for general use, but should be applied on the backs of the hands, and on the chest (near CV17) or navel. Begin this way, encouraging the client to focus on inhalation of these scents as they relax into the session.

Mild Depression Formula

2 tsp sweet almond oil (or other carrier oil)
8 drops ylang ylang
8 drops lavender
2 drops geranium
2 drops basil
2 drops bergamot

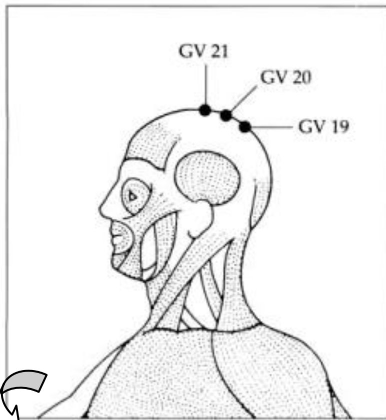
General Depression Formula

2 tsp carrier oil
6 drops each:
  bergamot
  lavender
  neroli
  basil

[14] Ingrid Martin, *Aromatherapy for Massage Practitioners* (Baltimore: Lippincott Williams & Wilkins, 2007) 202.

Acupressure

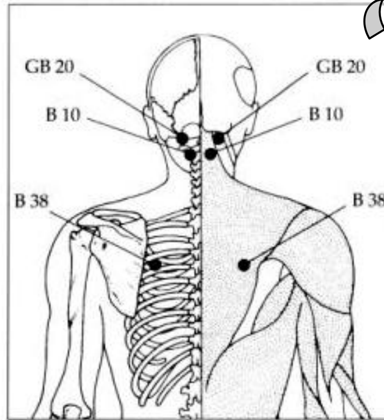
Acupressure is another effective modality that can help address energetic imbalances which may lead to depression. The following point suggestions, from *Acupressure's Potent Points* by Michael Gach, can be integrated into any kind of massage session, and only a few need to be used to have effect. Therapists familiar with the Jin Shin Do® Neck and Shoulder release will notice many of the same points listed below; beginning massage sessions with that release can be deeply relaxing for many people.



GV 19: *Posterior Summit*
GV 20: *100 Meeting Point*
GV 21: *Anterior Summit*

Find GV 20 by sliding up and over the head from just behind the ears, to a hollow toward the back of the head.

GV 21 is in the hollow anterior to that, and GV 19 in the hollow posterior.



B 38: *Vital Diagram*
Between the scapula and spine at heart level.

B 10: *Heavenly Pillar*
Half-inch inferior to base of skull, half-inch lateral to spine.

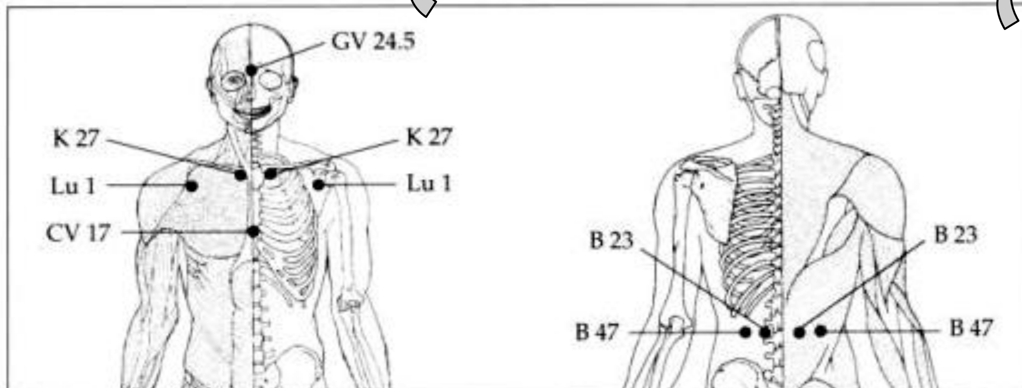
GB 20: *Gates of Consciousness*
At base of skull, on muscles that extend from mastoid process.

GV 24.5: *Third Eye*

K 27: *Elegant Mansion*
Between 1st rib and lower border of clavicle, just lateral to sternum.

Lu 1: *Letting Go*
Four finger widths superior of axilla fold, one finger width medial.

CV 17: *Sea of Tranquility*
Central on the sternum, three thumb widths from its base.



B 23 & B 47:
The Sea of Vitality

Two and four finger widths from spine at waist level.

CAUTION:
Do not hold with pressure on people with disc issues.

CONCLUSIONS

In a culture rampant with feel-good expectations and the pills to back them up, there is often little space for understanding the realities of depression and anxiety. Clients who deal with the devastating effects of being depressed are doubly burdened with social pressures that often leave them feeling they are outside of the fray, and further that they must "shape up" or lose the respect and love of people around them. As massage therapists, whether we can relate to clients dealing with depression or not, we must be aware of creating a space wherein these social pressures do not resonate. We must work with an awareness that allows us to partner with and guide our clients in honoring their sadness. And, even if our client feels "ghostly, transparent, unbelievable," we must be grounded, accepting, and trustworthy.

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