Chapter 17
Anxiety and depression

Our emotions and the chemistry of our brains are inextricably intertwined. Being in love causes the levels of the chemicals dopamine and oxytocin to rise – without, of course, our being aware this is happening.

So too with anxiety and depression. Worrying about something or feeling low both involve complex chemical changes in the brain. It is of course perfectly normal sometimes to have a low mood or to worry about things. But sometimes anxiety or depression – and sometimes both together – are severe enough to affect our lives day by day.

Researchers do not know the precise cause of depression. They believe it may be caused by a combination of circumstances in the environment together with psychological, biological and genetic factors. Fortunately, both conditions can be treated, however they have been caused. Drugs are available, as are talking therapies; indeed, there is plenty of research evidence for the success of both.

However, many people suffering from anxiety or depression do not seek help. Older people go to see their GP almost twice as often as other age groups, but only a third of older people who have depression raise their symptoms with their GP.[1]

Dr Fionnuala Edgar works as a clinical psychologist for the NHS in Dumfries and Galloway. Concerned at the low uptake of talking therapies among older people, she and her colleague Mary Hughes did some research in 2013 to try to work out why when launching a campaign to increase awareness of the benefits of therapy. In an account of that research and in an interview with me in 2016, Dr Edgar highlighted the following factors:

- older people often consider that having a low mood is an inevitable part of the ageing process. In fact, feeling tired of life may mean you have depression, which could be treated.
- they may feel that their depression or anxiety is an inevitable accompaniment of any physical health condition they have
- they may be unaware that their anxiety or depression is responsive to treatment
- a stigma around mental health – people may be reluctant to seek help because they fear what others may say
- they have feeling of worthlessness, perhaps the result of or exacerbated by depression. So someone might say, 'I shouldn't complain – there are other people worse off than me.' Dr Edgar would respond: 'Why are *you* not anybody else? This is having an effect on your ability to enjoy life and if we can help you have a better quality of life, then why not?'[2]

In this chapter I examine:

- the definitions of anxiety and depression
- problems to which anxiety and depression can give rise
- some of the common causes amongst older people
- how both conditions are diagnosed
- types of talking therapy
- drug treatment
- how to get the best treatment
- how therapy can help people facing bereavement, carer stress and sleep problems

Anxiety: definition, symptoms and causes

At what stage is anxiety different from just being understandably concerned about things in everyday life? Where does normal end and abnormal begin? The answer is when that worry starts to become present much of the time and the person has difficulty in controlling it.

Apart from near constant concern, generalised anxiety disorder (GAD) may have other symptoms. Somebody may become easily upset. Their sleep may be disrupted. They may have difficulty in concentrating, tension in their muscles and a feeling of being constantly jittery and on edge. They may have panic attacks.

Essentially, someone with GAD over-estimates a threat and under-estimates their ability to cope with it. As a result, their life starts to centre around their anxiety and the fear of what might happens leads them to avoid doing things. This can result in a vicious circle. Some people have what is known as social anxiety, so that they are constantly nervous of prompting negative reactions from other people. That may prevent them from going out. That isolation in turn perpetuates their anxiety, because they never learn that their social interactions in the outside world can be all right. Remaining at home may lead to loneliness, which may in turn lead to depression.

Similarly, some older people fail to step outside their front door because they have an intense and abiding fear of falling over. As with social anxiety, what they perceive to be safe behaviour sustains the belief that is fuelling their anxiety – and also denies them the benefits of going out and mixing with other people. Some people who fear going out develop agoraphobia, which involves anxiety in situations in which the person might find escape difficult or embarrassing, such as open spaces, crowds or public transport.

Being over-anxious about your health is another common form of anxiety. Having an illness or disability can cause people to worry a great deal. In some illnesses, the development of anxiety is a part of the physical illness. But in other cases it arises because someone is worried about their health, and it can become so severe that it makes dealing with the illness or disability more difficult to handle.

Some people worry about their health even though they have no physical illness. They are constantly checking for symptoms, seeking yet more information on the internet and frequently consulting their doctor. There again, some people may develop GAD not because they themselves are ill, but because they find themselves caring for someone else who is seriously ill. Carers are often even more reluctant to seek help for anxiety or depression than other people. Yet they could benefit much from learning how to manage carer stress. This not only helps them feel happier: it also helps ensure that the caring situation is more sustainable and does not break down because of the carer's mental condition.

One reason to seek help with anxiety is that it can lead to the development of depression. Someone who never goes out because of social anxiety may become intensely lonely, which in turn may lead to depression. About 40 per cent of older people who have depression also suffer anxiety disorders and in most cases of comorbidity (the two conditions existing side by side), the anxiety preceded depression.[3] So address anxiety as early as possible.

Depression: definition and symptoms

In 'Depression in later life: a personal account', Bronwen Loder recalled: 'About a year after retirement, I had become apathetic, withdrawn, and unable to concentrate and was sleeping badly. ... I had a particular problem with procrastination: was unable to open letters, pay bills or, at times, communicate with anybody. I felt I had lost my purpose in life.'[4]

Dr Loder had some of the common symptoms of depression. These include low mood but also fatigue, insomnia, loss of appetite, apathy and loss of interest or pleasure in the ordinary activities of life, experienced for at least a fortnight.[5] You do not need to have all these symptoms to have depression. As the National Institute for Health and Care Excellence (NICE) has pointed out, 'Depression is a broad and heterogeneous diagnosis. Central to it is depressed mood and/or loss of pleasure in most activities'.[6]

If someone has symptoms of depression, changes in the brain have probably taken place that include higher than normal levels of hormones associated with stress and a change in the levels of a chemical called serotonin. The ability of the person involved to function day-to-day may be impaired, so that they cannot look after themselves properly or lead a normal life.

The symptoms of bipolar disorder, formerly known as manic depression, are quite different. Genetic factors seem to play a larger part in triggering bipolar than other types of depression. It is far less common amongst older people than clinical depression and I do not consider it here.

What is the difference between depression and a feeling of being fed up? As with anxiety, depression is deemed to be present when a low mood starts to affect someone's day-to-day functioning. If they are depressed, they are probably not sleeping or eating properly. They may be thinking about suicide, as they feel life is no longer worth living. They may be withdrawn socially – from friends, from family, and from the activities they previously enjoyed.

Depression can make coping with other medical conditions more difficult. It can reduce the incentive to avoid other illnesses – by getting a flu or shingles jab, for example. You may not get enough to eat nor obtain enough exercise. Depression can have a massive impact on our social and emotional lives: lack of interest and pleasure in life can make us less entertaining company, so that the friends and even the partner who might have given support drop away.

Some people who have symptoms of depression take their own life. Nearly 500 men and more than 200 women aged 60 and over in the West

Midlands committed suicide between 1995 and 2004, for instance.[7] Various studies indicate that between about two-thirds and three-quarters of older people who killed themselves had showed symptoms of depression beforehand.[8] The attempts of older people to kill themselves are more likely to be successful than those of younger people: cries for help – attempts to influence other people without strong intent to actually die – are less common amongst older people.[9] As depression is treatable, much death and subsequent heartache could potentially be preventable.

Causes of depression

While anxiety is linked to fear, depression often stems from loss. Later life is a time when we tend to see many losses. It is also a time when we have time to contemplate those losses, and perhaps other losses that occurred earlier in our lives but at a time when we were too busy with family or work to process them. So what are the losses that can lead to depression in later life?

They are not difficult to find. There is the loss of one's job – and with that loss of income, self-esteem and a structure to one's life *(as discussed on page 85).* There is the loss of loved ones – someone might move away from their friends and family to live in another part of the country. Or people to whom they have been close, perhaps for decades, may die.

Illness and disability can give rise to losses. Thus loss of your eyesight is devastating in itself but so too can be the ramifications, such as having to surrender your driving licence, no longer enjoying particular places on holiday or having to leave one's home to relocate to a care facility or live with relatives. That disability is often associated with depression is hardly surprising. The after-effects of a major stroke, chronic heart or lung disease for instance, bring daunting psychological challenges. Thus my father had to cope during the last ten years of his life with progressively losing his ability to move around. Once he had scampered up cliff-sides with me and my brother; 15 years on, emphysema meant that he struggled to catch his breath when climbing stairs and could walk only a few yards before resting. In those days (the mid-1970s), mobility scooters and many of the other inventions for helping people who find walking difficult were pretty well unknown. My father bore his increasing confinement to his small terraced house imaginatively and cheerfully, but many people, myself included, would have bowed under the mental strain.

But while some people are unhappy as a result of changes in their lives such as these, they do not go on to develop depression. What is crucial is how people respond to situations – their attitudes and their behaviour.

That response may be shaped by their character, their resilience and the support or lack of it from others around them.

Resilience developed earlier in life can buffer the impact of loss. But sometimes emotional problems experienced much earlier, even in childhood weaken our ability to cope in later life. One study revealed higher rates of anxiety disorders, current sleep disturbance and emotional distress amongst survivors of the Holocaust than other people of a similar age.[10] Another has shown an association between the forcible displacement of people during World War Two and higher levels of anxiety together with lower levels of resilience and life satisfaction 60 years later on.[11]

A key feature of later life that can affect whether or not we develop anxiety or depression or indeed both is time and commitments. Retirement affords people a lot more leisure to think about their past experiences, both negative and positive. Some people will have experienced abuse in childhood or domestic violence during adulthood. Some will have experienced the loss of a loved one, such as a child, at a time when one was supposed to get over such loss quickly and perhaps never talk about it. Many things can happen to us in life which we do not process emotionally at the time, whether because we are told that is wrong or because the pace of work and family life preclude it. But when we come to retirement, that changes. And in our reflections, we will pick up on regrets or things that have not gone so well.

Dumfries and Galloway attracts many older people in retirement, perhaps taking advantage of low property prices and the benefits Scottish older people enjoy compare with their counterparts south of the border. Indeed, it has a higher proportion of older people in its population than any other region in Scotland. Dr Edgar explained to me:

> Often someone retires into the local community and then develops physical health problems. They have retired with high expectations of what retirement will look like, so they have lots of ambitions and plans for their retirement, but then suddenly these hopes are thwarted because of a physical health problem, such as a stroke. Because they've retired away from their support systems, with friends and family scattered elsewhere, they may not have local support. This combination of the stress of a serious health concern, coupled with a lack of support and an altered future can contribute to the development of low mood and anxiety. There may be other factors predisposing them to develop depression such as negative experiences in the earlier part of their lives which reduce their ability to cope with such difficulties in later life.

Diagnosis of anxiety and depression

Diagnosis of generalised anxiety disorder involves a GP or other health care professional using an assessment tool to try to work out whether the symptoms and the severity someone is feeling conform to those seen in GAD. There is no simple blood test. As we have noted, anxiety often arises in association with a physical illness. Now sometimes, this anxiety is indeed a characteristic symptom of that illness, but in other cases it develops separately. The doctor has to try to establish which is the case.

The diagnosis of clinical depression is not straightforward either: again, there is no simple blood test or brain scan. The first step is to rule out other medical causes for the low mood and any other symptoms being experienced. These can arise as a side-effect of medication (including certain cancer drugs, steroids, tranquillizers and beta-blockers). In addition, digestive disorders, diseases of the blood, thyroid problems, vitamin deficiencies and a brain tumour can all give rise to similar symptoms to depression.

Having ruled out other possible causes for symptoms, a GP will then seek to establish their nature, intensity and duration and the severity of their effect. There is doubt here too: it is unclear how low one's mood has to be before it becomes clinical depression, as opposed to a natural response to a depressing set of circumstances.

Expect to come away from seeing your GP with answers to the following questions:

- ✓ Have I got depression?
- ✓ If not, what is the cause of my symptoms?
- ✓ Should they be treated and if so, how?
- ✓ How bad is my depression?
- ✓ Is it possible to establish why I have developed depression?
- ✓ What treatment will I receive?

Take somebody with you to see the doctor, if possible. Your low mood may mean you fail to explain all that the doctor needs to know. You will probably not be in a fit state to press for a referral if your GP seems keen to write off your low feelings or simply give you tablets without considering any other approach. Also, another person can be invaluable in helping you monitor the effects of treatment and the side-effects of any medicines. Indeed, the attitude of those around somebody with depression is important: in a talk on depression among older people living in care homes, Professor Anthony Mann of King's College London

recommended that such people should be positive and talk of recovery, as people suffering from depression struggle to see a future without their depression.[12]

Even if your symptoms are not too bad at present, your GP should take them seriously. About 25 per cent of people with mild depression go on to develop severe depression within two years.[13] That said, many people (about 30 per cent) recover from their anxiety or depression without treatment.

Your GP should follow guidance published by NICE on anxiety or depression. The guidance NICE has issued is concise and readable and can be obtained free of charge from its website. Look for NICE Clinical Guideline 113 entitled *Generalised Anxiety Disorder and Panic Disorder in Adults: Management* (published in 2011) or Clinical Guideline 90: *Depression in Adults: the Treatment and Management of Depression in Adults*, (published in 2009). As depression is between two and three times more common in people with a chronic physical health problem and NICE considers that, 'Treating depression in people with a chronic physical health problem has the potential to increase their quality of life and life expectancy', it has also issued *Clinical Guideline on Depression in Adults with a Chronic Physical Health Problem: Recognition and Management* (published in 2009), to be read alongside its general guidance on the treatment of depression in adults.[14] The equivalent body to NICE in Scotland, the Scottish Intercollegiate Guidelines Network, has published broadly similar guidance.[15]

The voluntary organisations Depression Alliance and MIND offer a wealth of information and advice. They also have helplines, so you could ring up and talk to someone about whether you might perhaps have one of these conditions.

Help for which your GP can provide a gateway could take various forms:

Drug treatment

There has been much research into medication for both anxiety and depression in recent years and a psychiatrist would choose between a range of drugs which have antidepressant or anxiolytic (relieving anxiety) effects or both. This is a complex field in which the doctor is looking for a drug which is effective yet does not cause the person to become dependent on it or give rise to undesirable side-effects, such as making them sleepy. A psychiatrist would prescribe the drugs in the first instance and a community psychiatric nurse would visit the patient at home and monitor their effectiveness and any side effects. NICE recommends selective

serotonin reuptake inhibitor drugs (known as SSSRIs) for depression and generalised anxiety disorder, although other drugs are also available.[16]

Talking therapy

For non-medics, talking therapy is easier to understand. It would be carried out by a psychotherapist, counsellor or clinical psychologist *(these terms are defined on pages 316–7)*, although, as we see in a moment, self-help manuals are available which can help some people. The types of therapy most frequently used to treat anxiety and depression are as follows:

Cognitive behaviour therapy (CBT)

This is the most widely used approach and is based on the idea that people are not mentally disturbed by things in themselves, but by the attitudes they take towards them. The therapist would meet the person for a number of sessions and try to alter the way they think about their situation, rather than focusing on the roots of the problem. Together, the patient and therapist try to identify unhelpful thoughts, beliefs and types of behaviour to which the depressed person finds themself automatically reverting, and the situations that often prompt them. They then develop strategies for avoiding or altering those situations, or intercepting or modifying the thoughts.

Cognitive behaviour therapy for GAD would look for the situations or events and the automatic anxious thoughts which tend to trigger the anxiety. The therapist would go on to examine with the patient how this process can be interrupted or changed. Anxiety is often associated with a need for control and an inability to tolerate uncertainty. As a result, people try to control situations as much as they possibly can, in order to alleviate their anxiety. As we see in a moment, talking therapy can help them relinquish some of that control and accommodate uncertainty in their lives. The therapist might also teach the patient techniques to help them relax, such as deep breathing, progressive relaxation of the muscles and imagining pleasant situations. They might also consider sleep management *(see below)*. CBT has also been shown in research studies to have a high success rate for people with panic attacks and phobias. Treatment for agoraphobia involves desensitising the person to the thing that prompts their fear but with someone else alongside them, in a graded way, accompanied by relaxation and with CBT helping the person to develop skills to cope with their problem.

Interpersonal therapy

This is also a time-limited treatment (perhaps 12 to 16 sessions) in which someone is helped to assess the quality of their relationships with other people. Might recent changes in these relationships have led to their depression? Interpersonal therapy does not view interpersonal difficulties as the only cause of someone's depression but does try to explore their relationships with other people and develop methods of improving them.

Interpersonal therapy can be used to help someone depressed after a death. Discussion may reveal that grief at the loss of a partner is compounded by previous bereavements, and therapy could help the person process and adapt to these various losses. It may also be used to deal with disputes, transition in role (perhaps involving retirement), and difficulties in establishing and maintaining supportive relationships, for example.

Mindfulness

If someone is depressed and often ruminating about the past or worrying about the future it can be useful to focus on the here and now. Mindfulness seeks to enable someone to be aware of and open to their internal mental state and the external world at the present moment and in a non-judgmental way, without defining things as good or bad. It involves various techniques that help people to do this and is often used in conjunction with CBT.

Other therapies

Other therapies used might for instance help you to identify the activities in your life that give you most pleasure and help you plan to include them to a greater extent and increase the pleasure you take in them.

A therapist might help you identify activities which bring a sense of accomplishment. If you find yourself engaged in tasks which seem to have no end and thus offer no sense of achievement along the way, it is easy to fall into a low mood.

A good therapist will give whatever form of therapy would best suit the person and their situation – the various therapies can be adapted. So, if therapy should reveal that childhood abuse is affecting the situation now, they might try to tackle the problem through trauma-based CBT. Or the therapist may consider they would get better results from interpersonal therapy and look at relationships throughout the person's life and how these have been affected by early abuse. Often the process of disclosure of abuse itself can be cathartic, so that the therapist simply helps the person process the memory and resolve some of the feelings of shame and guilt that they have felt, perhaps over decades.

Make sure your therapist takes account of any difficulties you have, such as with hearing, vision or understanding. They should be ready to adapt their approach so as to proceed at a pace with which you are comfortable and if necessary give you material in large-print form.

The therapist will include other people close to you if that might be helpful and you agree. For instance, NICE recommends behavioural couples therapy for people with a physical health problem and moderate depression where their relationship with their partner may affect that depression.[17]

Self help

If your anxiety or depression is quite mild you could try to help yourself by using a manual which takes you through your problems using (mainly) cognitive behaviour therapy. There is an excellent series of books called the Overcoming series such as – *Overcoming Depression, Overcoming Anxiety* and *Overcoming Low Self-Esteem.*[18] They contain many sound suggestions for all of us, whether or not we have depression or anxiety. These books were originally published by Robinson, now by Little Brown.

Taking yourself through one of these manuals or perhaps a similar online package offers advantages – treatment at your convenience without taking time off work or other activities, being able to work at one's own pace and of course privacy and freedom from the stigma some people feel if they attend clinics. However, you do need sufficient self-motivation to take yourself through a self-help manual.

Another possibility is to attend group sessions provided by a voluntary organisation. For instance, many carers' centres *(page 630)* provide sessions for carers to help them manage stress.

Help through the NHS

If you go to your GP and your anxiety or depression is mild, you may well be referred to 'guided self-help', in other words, you go through a manual or workbook, but you have someone to support you in doing so. You may get help one-to-one or in a workshop or group. Your therapist might set you homework and/or phone you mid way between sessions to see how you are faring.

Cash has been put into the NHS in recent years to pay for guided self-help for psychological conditions that are at a mild stage; thousands of people have been trained to provide CBT-based talking therapy in a little-known government initiative called Improving Access to Psychological Therapies (IAPT).

You should not have to wait long for a referral. Waiting time targets set down in the NHS Constitution state that 75 per cent of people should receive treatment within six weeks and 95 per cent within 18 weeks if they have been referred to the IAPT programme. Scotland uses a similar approach but does not call it IAPT. There, supported self-help often uses an online resource called Moodjuice.

In many centres you can self-refer for IAPT. Or a friend or family member could refer you, with your consent.

However, many people will need more help than this, because their anxiety or depression is more serious or the causes complex. Sometimes a stepped approach is tried with guided self help going on to one-to-one therapy if the former does not provide enough help.

In the past, GPs often gave patients medication without considering talking therapy. There are pros and cons with each approach; much depends on the cause of the condition and its severity. Talking therapy can provide a toolkit for managing depression in the short-term, as well as a strategy should the condition return. That said, drugs can also be effective, particularly if the depression is severe. Sometimes a combination of drugs and therapy works best.

Doctors may have given antidepressants to patients with symptoms of depression as a matter of routine in times past, but they should not be doing so now. NICE enjoins doctors as follows: 'Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression.' Instead, doctors should consider them only for people with a past history of moderate or severe depression; those with symptoms which do not seem to reach the threshold for classification as depression yet have been present for a long period (typically at least two years); and in cases of subthreshold depression symptoms or mild depression which persist after other treatments have been tried.[19]

For people with moderate or severe depression, doctors should offer patients, 'A combination of antidepressant medication *and* a high-intensity psychological intervention (cognitive behaviour therapy or interpersonal therapy)'. (my emphasis)[20]

The National Service Framework for Older People *(see page 300)* takes mental health seriously, devoting a chapter to the condition. For depression it recommends treatments not involving drugs as the 'first line management wherever possible, such as cognitive behaviour therapy and individual counselling and support'.[21]

Overcoming anxiety and depression is not always easy. Not everyone will respond to the treatment first offered to them. Be ready to ask to try

different medication or at a different dose. If you don't develop a rapport with the therapist allocated to you, ask for another.

Mental health is covered by the Choose and Book system, which provides choice for patients in England who are referred for specialist treatment *(page 905)*. Wherever you live in the UK, expect to be offered a choice in the way you are treated: patient choice is a fundamental principle of the NHS Constitution *(see page 285)*.

If you or your loved one has dementia and also has depression the latter should be addressed as recommended by NICE *(explained on page 289)*.

Practical support

Enlist your therapist or GP's help to address any problems which are adding to your anxiety or depression. For instance, if you are struggling with anxiety or depression related to being a carer, ask your therapist or GP to help you secure practical help to enable you to cope. They could write to social services and ask that you be given a carer's assessment of the practical support you need *(as explained on page 621)*. In any case, if you are a carer do make contact with your nearest carers' centre *(page 630)*. These centres can provide a gateway to much help and some provide group sessions in relaxation and managing stress, as well as one-to-one counselling.

Uses of therapy

Finally, let us look briefly at the ways in which talking therapy can be used for some common causes or symptoms of depression and anxiety in later life.

Sleep problems

Many people particularly with anxiety but also with depression do not sleep well. A therapist would look at basic sleep hygiene – how someone is preparing their body for sleep. They would consider the temperature of the room and any other physical factors that might prevent or disrupt sleep such as noise or the consumption of a large amount of food or alcohol before going to bed. Another is the need to go to the toilet. If someone needs to go frequently, the therapist would suggest they consult their GP about possible causes – perhaps an overactive prostate gland.

Relaxing before going to bed is important. So a therapist would suggest winding down activities and teach relaxation exercises.

However, sleeplessness often results from worry – someone wakes during the night and a constant, pervasive concern prevents their getting

back to sleep. That worry might be about a family situation, perhaps, or money matters or illness.

The therapist would try to help the person work through it – accepting that there are aspects of the situation they cannot alter, thinking what practical steps they could take to do something about it and helping them tolerate uncertainty.

Another common cause of insomnia is rehearsing in the mind something you have done that day or anticipating all the things you have to do. Professor Colin Espie is the author of the excellent self-help guide *Overcoming Insomnia and Sleep Problems*; therapists often use Professor Espie's suggestions. So they might encourage you to devote a short time in the early evening to putting the day to rest – writing down on paper what has happened and what you felt good about and what has troubled you. You would also write down a list of things you need to do and set down anything you are unsure about, considering in advance things you are looking forward to and things you worry about. All this should leave you feeling more in control. Another simple tip is to keep a piece of paper beside your bed so you can write things down in the middle of the night to be dealt with the following morning.

Blocking distracting thoughts can also be helpful. Professor Espie recommends thinking the word 'the' to oneself slowly and calmly every two seconds. He believes that helps block out other thoughts, disconnects us from the outside world and helps us fall asleep.

Bereavement

If you have lost a loved one such as your partner and are finding it difficult to get through your grief, you could approach Cruse Bereavement Care. Trained bereavement support volunteers give one-to-one help and group support throughout England, Wales and Northern Ireland; Cruse Bereavement Care Scotland provides a similar service. Trained volunteers also give help via a phone helpline and responding to email messages. The emotions you are feeling may be perfectly normal but it can be difficult to know whether they are, as coping with bereavement is not much discussed in our society.

If you are continuing to feel low six months after the death of a loved one, do go and see your GP and ask for a referral to a counsellor, psychotherapist or clinical psychologist. He or she should help you cope better with your bereavement. Some people feel that they should be over a bereavement, say, a year after it has taken place. But response to bereavement is very individual and much of the therapy may involve helping you

to normalise your reactions. It is OK to have good days and bad days and to move forward on that basis.

Therapy often involves not trying to work your way through the stages of grief that were used in the past[22] but helping you cope with inevitable fluctuations between being able to function and then suddenly being thrown into a raw state of grief by a trigger such as an anniversary. Rather than expecting you to progress in discrete stages, the process should be dynamic and changing; this is the dual process theory of bereavement.[23] The aim would be to ensure that the swings you experience between matters related to loss and those related to restoration gradually result in the latter becoming more prominent over time. But the therapist would try to help you cope with prompts such as seeing a photograph or visiting a grave, rather than avoiding them.

Dr Edgar told me:

> Sometimes it is about finding out about the relationship someone had with the person who has died and their beliefs and thoughts on moving forward. Often there can be guilt about carving out a new life for themselves without the person who has passed away; for some people, it can be about giving them permission to move on. The therapist helps them realise that moving on isn't going to affect their memory or the memories that they have with that person, but it is about supporting them to find a new normal. It's not like life getting back to normal, because life is never going to be the same as it was, but it's about carving out what they want the rest of their life to look like. Often it can be reflecting on if the reverse had happened: if they had died, would they want their spouse or partner to live like this, with this kind of homage to the previous relationship? Or would they want them to move forward? So we are trying to explore what are the barriers to them actually living life the way they would like to live, what were their expectations of life and how can those expectations be met in a different way, without their loved one.

Anxiety and depression

* Depression is not an inevitable part of growing older.
* Difficulties with bereavement, the psychological challenges of illness and disability, family situations, carer stress, sleep problems and many others can be helped by talking therapy.
* Anxiety is often related to fear and depression to loss.
* There are sophisticated self-help manuals which can help some people.
* Recent research has shown that talking therapy and drugs are often effective.
* Don't be ashamed of having depression or anxiety
* Two thirds of older people with depression have never discussed it with their GP.
* Suicide attempts by older people are much more likely to succeed.
* Involve friends and family in your treatment and find a support group if possible.
* Enlist the help of your doctor to get changes in your living conditions, say, in a care home, if they are making you anxious or depressed.