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CHAPTER 8

Domestic abuse

Roxane Agnew-Davies and Louise Howard

Kim's story

My mother was always critical of me and my father left when I was a child. When John and I started going out, he was attentive and I felt I had found someone who cared for me at last. Looking back, his interested questions always turned into an interrogation about who had talked to or texted me, especially men. He became jealous and possessive, even though I was totally in love. Things got worse when I became pregnant. When I didn't feel like sex, he accused me of having an affair and called me a whore. Basically, I often had sex to keep the peace, even when I didn't feel well. I really didn't like oral sex, but as my belly got bigger, John insisted it was my job to give him pleasure. It really hurt a few times. I got more and more depressed, and John got angrier. I felt too ashamed to ask anyone about it, and I could never have told my mother something like that. Even if it was embarrassing, it was a relief when my midwife asked me if things were okay between me and my partner, and if we had any sexual problems during pregnancy. When I told her, she explained that it was sexual abuse if John did not take 'no' for an answer when I did not really want to have sex. She referred me to a Relate counsellor and that really helped. The counsellor saw us separately at first, and thinking about my rights and that I was not to blame, really helped my self-confidence. I realised that I was a good person and I would rather be on my own than be put down or forced into things, by Mum or John. I left John for a while and that gave us both some breathing space. When Gemma was born, John promised that he would respect me and protect us both. It's good to have a family at last.

What is domestic abuse?

Domestic abuse (or domestic violence) is a pattern of coercive and controlling behaviour by a partner or family member that can include physical violence, sexual violence, emotional/psychological abuse (such as humiliation) and financial exploitation.

Physical violence can range from minor assaults, like a slap or a kick, to serious injuries that result in death. Sexual violence is any kind of sexual activity without consent – the willing agreement of someone to choose to have sex. It includes rape or penetration of the mouth, vagina or anus by a penis or an instrument such as a bottle or knife. Sexual assault is any kind of intentional sexual touching of somebody else without their consent. It is also child abuse if the person is under 16 years of age. Emotional abuse can be less obvious but can have a severe impact on mental and physical health. Women are much more likely to be victims of severe and repeated episodes of domestic abuse than men.

How common is domestic abuse?

Around 6% of all adults aged 16–59 have experienced domestic abuse in the last year; 70–80% of abuse victims are women (Office for National Statistics, 2016, 2017). Men are far more likely to commit domestic abuse than women – in the year ending March 2016, 92% of defendants in domestic abuse prosecurtions were male (Office of National Statistics, 2016). However, one survey found that a quarter of all gay and bisexual women have experienced violence within a relationship, and in two-thirds of these cases the perpetrator was female (Hunt & Fish, 2008).

What increases vulnerability?

Seeing domestic abuse or being abused as a child is associated with experiencing domestic abuse as an adult, but domestic abuse can happen to any woman. Some women are more vulnerable if their families or friends ignore or collude with the abuse, for example by refusing to believe them, or by forcing them into marriage.

How does domestic abuse affect women?

All experiences of domestic abuse are traumatic. A woman's reaction will depend on a lot of things, like what happened, what support she has, if someone has hurt her before, and her personal strengths and situation.

Most women re-live or think about what happened, have bad dreams or feel confused. It is natural to try to push away these upsetting thoughts and feelings, but they might pop up anyway. They might feel numb and want to avoid certain people and places. It is normal to feel afraid, jumpy or on edge, and also to feel down and negative. Women might feel differently about relationships than they did before, be irritable and have angry outbursts. It can be harder to concentrate, to manage everyday life, to socialise or to look forward to the future. A woman's view of the abuser and perhaps of themselves might change. It can be hard to make sense of a world that is not safe, when you did not have the power to stop it and when others did not help. Sexual difficulties are common after rape.

Tips for women who have experienced domestic abuse

Safety comes first. If you are still at risk, talk to someone close to you or to a helpline about making a safety plan to protect you from future harm. Think of yourself as a customer in a shop; if you do not find what you need the first time you look or ask, try someone else (Box 8.1).

Healing can include coming to terms with what happened and being able to move on. Here are some ideas to think about:

- The abuse was outside your control and not what you wanted.
- What was done to you does not define you as a person because it was not your free choice or your fault, and is only one part of your life.
- Bad things happen to good people: 20% of women experience sexual violence and 25% of women experience domestic abuse.
- Many women do get over domestic abuse in their own time and learn to cope in their own way.

Box 8.1 Support organisations

- Free national domestic abuse helpline: 0808 2000 247
  www.refuge.org.uk
  www.womensaid.org.uk
- Forced marriage: www.fco.gov.uk
- Lesbian support services:
  http://lgbtdaf.org/category/lgbt-services-a-z
- Rape Crisis Centres: 0808 802 9999 (England and Wales), 08088 010302 (Scotland)
- Sexual assault referral centres:
  www.thesurvivorstrust.org/sarc
  www.thehavens.co.uk (London)
- The Survivors Trust lists local specialist services across the UK and Ireland and offers information for survivors.
  www.thesurvivorstrust.org

- It takes time, and you might work through shock, grief, anger and strong feelings about yourself and other people, not just the abuser.
- Take care of your body (e.g. medical checks, healthy eating, relaxation and exercise).

Understanding your reactions can help. Traumatic memories are uncomfortable. It can help to know that there are reasons they keep coming back:

- as a means to learn how to keep safe in the future
- because you could not process your thoughts and feelings at the time, when you were in a state of shock.

They can lessen when you have developed a safety plan, and feel sure that the past cannot happen again.

If you write down what you were thinking and feeling at the time and how it affected you, or better still, talk to someone about it, it can help recovery. Trying to bury the memories might feel easier in the short term, but they can spring back, a bit like trying to push a coiled spring down. If you start using drink or drugs to block things out, that will not be good for you in the long run – drug and alcohol use can worsen existing mental health problems or even bring on new ones.

Help is available

Independent Sexual Violence Advisors (ISVAs) are women trained to support victims of sexual assault and Independent Domestic Violence Advocates (IDVAs) are people trained to support victims of domestic abuse. They assess risks, can help with safety planning, give support during legal proceedings and contact other agencies.

Sexual assault referral centres have trained staff who can give information, medical help and counselling. Medical support includes emergency contraception and screening for infections. Centres can help women speak to the police, although they do not have to.

Rape Crisis Centres provide specialised support, counselling and advocacy for women who have experienced any type of sexual violence at any time in their lives, whether recently or in the past. This might be as an individual or in a group, and include information and active support. Having someone who listens and understands can help women make sense of what happened and speed recovery.

Mental health problems resulting from domestic abuse, such as chronic or complex post-traumatic stress disorder can be successfully treated with cognitive–behavioural therapy (known as CBT) or eye movement desensitization and re-processing (EMDR), usually over 9 to 12 sessions. Using different methods, both help the processing of thoughts or memories about the abuse without feeling afraid and the development of resources to cope better. See Box 8.1 for a list of support organisations.

Tips for family and friends

Hearing that someone you love has been a victim of domestic abuse is shocking and disturbing, especially if you know the abuser. Remember that the person responsible for the abuse was the abuser, not the victim. Try to be non-judgmental about her reaction and do not guess what you might have done. If you are angry or upset about what happened, be clear that you are not angry at the victim, but recognise that she is frightened and hurt. Ask what she needs for support.

Remind her of the qualities or characteristics or skills you respect and admire about her. The best sort of support will mean leaving the door open for her to talk as much or as little as she wants, when she is ready, and for as long as she needs.

Useful resources

For women who have experienced abuse

Bass E, Davis L (1988) *The Courage to Heal*. Vermilion.

Gil E (1988) *Outgrowing the Pain*. Dell.

Matsakis A (1998) *Trust After Trauma*. New Harbinger.

For family

Gil E (1992) *Outgrowing the Pain Together*. Dell.

For professionals

Herman JL (1998) *Trauma and Recovery: From Domestic Abuse to Political Terror*. Pandora.

Foa EB, Rothbaum BO (1998) *Treating the Trauma of Rape: Cognitive–Behavioral Therapy for PTSD*. The Guilford Press.

Online eLearning course

Social Care Institute for Excellence
Sexual Reproductive and Mental Health
eLearningscie.org.uk/publications/elearning/sexualhealth/index.asp

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CHAPTER 9

Women and the criminal justice system

Annie Bartlett

Jo's story

Jo is 38 years old. She has three children. She has a long history of street drug use and has been in contact with community drug services for over 10 years. More recently, she has also drunk alcohol heavily. She has had some previous contact with the criminal justice system as a result of her sex work, but only one episode of imprisonment following a minor assault. She has now been arrested because she stabbed her male partner.

She was seen at court by mental health liaison workers, but the seriousness of her criminal charge meant that she was remanded into custody. When she arrived in prison, she was sent to the prison wing specialising in drug and alcohol detoxification. At the end of this she seemed depressed and was seen by the mental health team. They established that, for many years, she had suffered with voices; these were unpleasant and distressing and dated from her experience of sexual abuse in childhood. She had self-medicated with street drugs from an early age and now, sober for the first time in years, she wanted other ways to manage her problems. She began attending a group to help her manage her voices.

She discussed her feelings of loss about her two oldest children, who were in care. Her youngest child lived with her mother. She was also worried about her offence. Though intelligent, it became clear that she lacked confidence. Her partner had undermined her and was periodically physically violent to her. She had poor basic literacy. She had never held regular employment.

There are a lot of women like Jo who are in contact with the criminal justice system. Most of them are in fact not violent but, if they are, the consequences can be serious not only for them, but also for their children. To understand how typical Jo's

story is, let's explore common experiences in the background of female offenders, the kinds of mental illness they have, what happens after someone is arrested and the services that are there to help them.

Numbers, conditions and problems

Women constitute about 5% of the total prison population and about 15% of those who are under the supervision of criminal justice services in the community. Serious violent offending by women is rare, and only a tiny number of women commit sexual offences. The total number of murder convictions in 2011 in England and Wales was 3423, of which 23 (7%) were of women. Serious criminal cases are considered by the Crown Court, where 1 in 10 sentenced cases have female defendants. Less serious cases are heard at magistrates' courts, where women account for closer to 1 in 3 of those sentenced (Ministry of Justice, 2012*a*).

Female offenders often come from troubled backgrounds. Half have been physically or sexually abused in childhood, and a third have spent time in the care system. A third have been expelled or permanently excluded from school, giving them little chance of stable employment in adult life.

Approximately 1 in 5 prisoners who are 18–20 years of age have children, versus 4% of the general population in that age group. The consequences of a mother's imprisonment for these children can include having to move house, being looked after by the extended family, or being taken into care (Ministry of Justice, 2012*b*).

Women in contact with the criminal justice system are more likely to have mental health problems than women who aren't (Singleton *et al*, 1998; O'Brien *et al*, 2003). These problems can include major mental illnesses that require contact with specialist psychiatric services, as well as the kind of problems usually dealt with by GPs.

Many of these women have drug and alcohol problems. These are costly in physical, psychological and social terms. There are physical consequences, such as blood-borne viruses, blood clots, accidents. They might experience social adversity stemming from sex work and street homelessness linked to addictions.

Difficulties in childhood frequently contribute to adult personality problems. Female offenders can be emotionally volatile, have problems forming stable adult relationships and commonly self-harm (particularly in prison custody). This is in addition to having a tendency to ignore social norms and break the law. The degree to which women have these problems is evident from the fact that many women have more than one psychiatric disorder. Lately, it has been thought important to think not only about female offenders' mental health problems, but about other stressors they experience, such as no stable accommodation, debt and violence in their adult relationships.

Female and male offenders tend to commit different crimes and have different mental health problems (Hodgkins *et al*, 1996; Wessely, 1997), and there are also gender-specific explanations of women's crime and violence (Farrington & Painter, 2004; Corston, 2007; Gelsthorpe, 2007). Broadly, women are less likely than men to be violent, but proportionately more likely to be violent to family members (e.g. partners, children), and more likely than violent men to have specific mental disorders. Women convicted of homicide are more likely to have a mental illness than men (Simpson *et al*, 2004; Flynn *et al*, 2011).

Treatment

Women in contact with the criminal justice system might be diagnosed with mental illness that requires treatment and/or diversion out of the criminal justice system into the health service. Opportunities for these women to get treatment can occur when they are arrested, in the magistrates' court, on remand in prison, when they are sentenced for criminal offences, and after they have received a prison sentence. This system relies on close working relationships between criminal justice agencies and healthcare staff.

Historically, services to intervene early, in a process that can last many months, have not been a well-funded part of healthcare. Multiple reports have made recommendations to improve liaison between the courts and health services to allow diversion (Corston, 2007; Bartlett *et al*, 2012).

Entry to prison means undergoing a comprehensive screen on arrival for urgent and important health problems, including whether they need detoxification from street drugs and

alcohol. Detoxification can lead to further psychosocial work on a woman's addictions, as well as slow withdrawal after stabilisation on opiates or benzodiazepines.

Routes of care after arrest include:

- diversion from police cells or magistrates' courts into specialist community healthcare
- custody (on remand or after sentencing) with care provided by health agencies in prison
- psychiatric hospital admission from court (magistrate or Crown) or from prison
- community criminal justice sanction with contact with GP services, community drug teams or community-based mental health teams

Women charged with serious offences will probably come to trial. Even if mental illness has contributed significantly to their offences, they are likely to be convicted prior to any hospital placement. The assessment of future risk will also be relevant; courts consider carefully the likelihood of serious harm to anyone in the future. Particular legal measures can be put into place to reduce this likelihood, even if the woman goes to hospital. In the case of a violent offence, if a woman goes to a psychiatric hospital, it will be to a secure unit. There, a range of psychological and pharmaceutical treatments will be available to them.

Most women have short stays in prison, with only a small percentage of women serving more than 12 months. Women with convictions for violence are more likely to receive longer sentences. A range of primary-care, psychiatric and psychological services are available in prison, depending on need and circumstance. Trials of psychological interventions have mainly been undertaken in other jurisdictions (e.g. for trauma symptoms, substance misuse).

Sentence planning is led by National Offender Management System staff and can involve placement in particular prisons with specialised services. For example, HMP Low Newton is suitable for women who pose particularly high risks, by virtue of personality disorders, and HMP Foston Hall offers the CARE (Choices, Actions, Relationships, Emotions) programme for women serving long sentences. Health and social care staff should work closely with criminal justice staff to make sure that all the woman's needs are met.

After prison

Coming out of prison, women might gain assistance from criminal justice agencies and specialist care, either in the NHS or the voluntary sector (e.g. Women in Prison). The intention is to help women settle back into community life and to improve their opportunities and quality of life. The re-offending rate after 1 year for women is 17.6% (compared with 27.0% for men; Ministry of Justice, 2012*a*).

Conclusions

The existing, imperfect system of care for women in contact with the criminal justice system is changing rapidly. Both the number and type of women's prisons, as well as the secure hospital system, were reviewed by the government (Robinson, 2013). There was a new emphasis on housing women in prisons in metropolitan areas to help them maintain family contact and an attempt to reserve secure hospital care and imprisonment for the small number of women who really need it because of the risk they pose to others. Despite the closure of HM Prison Holloway in 2016 and the relocation of many London female prisoners to prisons in Surrey, this remains the government's intention. A strategy on women offenders is due to be released in 2017, and the current plan is to create five community prisons to improve rehabilitation chances for women like Jo (Ministry of Justice, 2016).

Tips for family and friends

- Prison and secure hospital visits need to be organised in advance, especially if they involve children. Information on visits and what to expect if someone you know is in prison is available from the Prison Reform Trust's website (http://www.prisonreformtrust.org.uk/ForPrisonersFamilies/Frequentlyaskedquestions).
- Leaving prison or hospital is a welcome but often difficult step, during which women need support. There are a range of organisations that can help with this, including Women in Prison (www.womeninprison.org.uk) and Wish (www.womenatwish.org.uk).

Useful resources

Department of Health (2002) *Women's Mental Health: Into the Mainstream*. DoH (http://webarchive.nationalarchives.gov.uk/20050315021049/http://www.dh.gov.uk/assetRoot/04/07/54/87/04075487.pdf).

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Flynn S, Abel KM, While D, *et al* (2011) Mental illness, gender and homicide: a population-based descriptive study. *Psychiatric Research*, **185**, 368–75.

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Ministry of Justice (2012b) *Prisoners' Childhood and Family Backgrounds: Ministry of Justice Research Series 4*. MoJ.

Ministry of Justice (2016) *Prison Safety and Reform*. MoJ.

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Robinson C (2013) *Women's Custodial Estate Review*. National Offender Management Service.

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Singleton N, Meltzer H, Gatward R (1998) *Psychiatric morbidity among prisoners in England and Wales*. TSO (The Stationery Office).

Wessely S (1997) The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, **170**, 8–11.

CHAPTER 18

Depression and other mood disorders

Paul Blenkiron

Amanda's story

At first Amanda didn't know what was wrong. She kept waking up and worrying about her children. She stopped going shopping with her friends. She was tired all the time, and found it took a huge effort just to get dinner ready. She began to snap and shout at her family. Her husband John didn't understand what was happening, and found it difficult to cope with her loss of interest in sex.

Every day Amanda felt like she was going around in a fog. She began to call in in sick to work, and have suicidal thoughts. John caught her with a handful of pills, and convinced her to seek help. She was diagnosed with depression and prescribed antidepressant medication. Amanda began to regain her energy, appetite and ability to sleep. She also started psychological therapy, which she found helped her manage her moods and start doing normal things again. She felt the fog had lifted and was able to go back to work.

It's normal to feel sad, fed up or miserable at times. But if you feel low for weeks or months, and it's so bad it affects your life, it might be depression.

Depression is a leading cause of disability in the world today. It is very common: 1 in 5 women and 1 in 8 men are affected, often between 20 and 55 years of age. Famous women who have been depressed include the actress Angelina Jolie, the author JK Rowling, the singer Karen Carpenter and the comedienne Ruby Wax. The good news is that, once depression is recognised, there are effective treatments and ways to prevent it coming back.

What types of mood disorder affect women?

Clinical depression (also called major depressive disorder)

Depression is more than sadness, grief or disappointment. It can affect every area of your life, physically as well as mentally. Everyone is different, but most women with depression have at least four of the ten symptoms listed in Box 18.1.

Box 18.1 Ten symptoms of depression

D – Depressed mood (feeling low most of the time)

E – Energy lost (feeling utterly tired or irritable)

P – Pleasure lost (no interest in life, can't enjoy anything, including sex)

R – Restless (agitated) or retarded (slowed down)

E – Eating habits changed (appetite or weight goes up or down)

S – Sleep changed (more or less than usual)

S – Suicidal thoughts or feeling life is not worth living

I – I'm a failure (thinking you are worthless or inadequate)

O – Only me to blame (feeling guilty and self-critical)

N – No concentration (not able to function or make decisions)

Bipolar disorder (previously called manic depression)

Bipolar disorder is a serious illness that affects 1 in 50 women and men. As well as depression, there are periods of high mood lasting days to weeks. These highs are called hypomania - or mania if more severe. You feel elated, full of energy, overactive or irritable. You sleep and eat less and may behave out of character, for example travelling, spending or making reckless plans. For some women, it can be a time when there is a real vulnerability to financial or sexual exploitation. Bipolar disorder is not the same as having quicker mood swings every few minutes or hours.

Postnatal depression

Between 10% and 30% of women become significantly depressed around the time of childbirth (Chapter 31).

Pre-menstrual dysphoric disorder (PMDD)

Women with PMDD feel tense, irritable, bloated and low, starting 10–14 days before menstruation. The symptoms improve after menstruation starts. Women who are prone to PMDD are also more likely to develop problems with low mood after childbirth and across the menopause.

Seasonal affective disorder (SAD)

Women with SAD get depressed in the winter when there is less daylight, but the depression goes away every spring. Symptoms include feeling tired and low, sleeping and eating more, craving carbohydrates and weight gain. It affects more women than men.

What causes depression in women?

Depression is not a sign of weakness or personal failure. You cannot just 'snap out of it'. It often runs in families, so genes are important. Life events can also trigger depression – for example, relationship difficulties, debts or losing a relative. So can drinking too much alcohol and physical health problems like arthritis, chronic pain or an under-active thyroid. In about 1 in 5 people, depression comes 'out of the blue' – that is, without an identifiable cause. Women are twice as likely as men to develop depression, and there are many potential reasons for this.

- Upbringing – women are more likely to suffer from childhood trauma, sexual abuse, victimisation and domestic violence (Chapter 7).
- Psychology – from puberty onwards, girls are more likely to worry about their body image. Women also tend more to look inwards and dwell on distressing feelings. Studies show this can trigger depression (Noel-Hoeksema *et al*, 1999).
- Hormones – female hormones and the reproductive cycle can affect mood. This can relate to the menstrual cycle,

pregnancy, childbirth, menopause, infertility, miscarriage, the contraceptive pill and hormone replacement therapy. However, it is often the life changes associated with these things, rather than hormones themselves, that lead to longer-lasting depression.

- Responsibilities – women are more likely to be in caring roles that make them vulnerable to depression, such as looking after small children or someone with a serious illness. When children leave home, women who have spent their lives caring for them can suffer from 'empty nest syndrome'.
- Circumstances – poverty and lack of equality or choice can affect mental health. Women make up 70% of the world's poor and two-thirds of low-paid workers, and own less than 1% of the world's property (Global Citizen, 2012). A satisfying job can improve well-being, but also cause stress by clashing with childcare and home responsibilities.

Differences in depression between women and men

The symptoms and outlook for depression are similar in both genders, but there are some differences.

- Women are more likely to admit they have a problem and seek help; men frequently bottle up their feelings.
- Women report more food cravings, weight gain, fatigue and health anxiety.
- Women often 'self-medicate' using food or friends, whereas men tend to cope using distraction and activities like TV, sport or sex.
- Women tend to avoid conflict, blame themselves or criticise their appearance; men may take things out on their surroundings, get aggressive, blame others or drink heavily.

Bipolar disorder in women and men

Women with bipolar disorder are more likely than men to experience changes in their appetite and weight. They might develop an eating disorder or a thyroid problem. Women

with bipolar disorder are less likely than men to have certain difficulties with their behaviour, such as over-using drugs and alcohol, gambling, and trouble with the law.

In women, the menstrual cycle, pregnancy and the menopause can affect periods of depression or high mood. Women are also more likely to develop 'rapid cycling', which is having more than two episodes of highs or lows in a year. Rapid cycling often links with reproductive cycles and can mean longer, deeper depressions that can be difficult to treat. The chances of a woman developing bipolar disorder are much higher just after giving birth, but mood-stabilising medication can help to prevent this.

Tips for women with a mood disorder

- Taking action can be hard, but it's worth it. Often it's the things you don't feel like doing that help.
- Recognise that you have a mood disorder. Look up your symptoms online; get professional help by talking to your GP as a first step.
- Tell others how you feel – especially if you have suicidal thoughts. It does not mean you are weak or crazy.
- Sleep at regular times, but do not stay in bed or nap in the daytime – do something active.
- Eat regularly, with plenty of fruit and vegetables, and avoiding junk food, which will only make you feel worse.
- Avoid alcohol and street drugs, as they make things worse.
- Get into a daily routine with a structure. Do the things you usually enjoy.
- Do not avoid tasks. Make a start today. Break big things into small steps.
- Exercise regularly in any way you enjoy – you could try swimming, running, yoga, going to the gym, or simply walking for 15 min a day.
- Notice your negative thinking. It is like having a critical devil on your shoulder. Challenge it! Say, 'This is not me – it's the depression talking'.

Treatments available

Depression often improves on its own after a few months, but there is a 50% chance it will come back in the future. Most women get help through their GP, and don't need to see a psychiatrist. Treatment can involve a talking therapy, medication, or both. These work for at least 70% of women getting help via their GP. Others may need help from specialist mental health services.

Talking therapy

- Cognitive–behavioural therapy (CBT) is an effective treatment for depression and other mental health problems (Box 18.2). CBT can be done face-to-face or in groups with a professional, or at home guided by a book, mobile app or internet program.
- Problem-solving is helpful for tackling practical problems, step by step.
- Counselling: talking through things can help (e.g. Cruse Bereavement Care).
- Couples therapy is useful for relationship problems (e.g. Relate).
- Mindfulness involves practicing paying real attention to what you are doing right at this moment, rather than getting involved with upsetting thoughts.

Box 18.2 What is cognitive–behavioural therapy?

Cognitive–behavioural therapy (often referred to as CBT) teaches more helpful ways of thinking and reacting in everyday situations.

- Cognitive – what you think. You learn to spot when you are being negative and self-critical. You challenge thoughts such as 'I'll never get better', 'It's all going wrong' or 'I'm useless'. You develop more helpful, realistic thinking habits by asking: 'What's the evidence this is true?', 'What's another way to view this?' and 'How would I advise a friend in my situation?'
- Behavioural – what you do. You keep a daily diary of activities – then set goals to do things that boost your mood and give you a sense of achievement.
- Therapy – what you learn. CBT works best if you practice new skills as 'homework'. This helps you stay well in the future too.

- Interpersonal therapy and psychodynamic therapy examine how past experiences might be causing current difficulties in life and relationships.

Medication

Depression

Modern antidepressant drugs are safe and effective. They help around two-thirds of women with depression, especially in more severe cases. For many women with a mild to moderate depression, medication is not necessarily needed and other treatments are just as likely to work.

Antidepressants work by boosting levels of natural brain chemicals that can be lower in depression. Some types, such as selective serotonin-reuptake inhibitors (SSRIs), might work better in women than in men. Common side-effects with SSRIs include dry mouth, headache and reduced appetite. Some people may experience dizziness, anxiety, agitation, diarrhoea, constipation or sexual problems. These usually wear off and you start noticing the benefits after 2–4 weeks.

St John's Wort might also relieve mild to moderate depression, but do not take this if you take any other medication, including the contraceptive pill.

Bipolar disorder

A mood-stabilising drug (e.g. lithium, valproate, quetiapine) is the main treatment for both the highs and lows of bipolar disorder, and also for prevention. Some medicines used to treat bipolar disorder can affect an unborn baby. It is important that women with bipolar disorder use effective contraception and discuss any plans to start a family with their GP well in advance. Valproate is best avoided in young women, as it can interfere with the reproductive system and harm the baby if the woman becomes pregnant. If a woman is taking valproate already and has been thinking about getting pregnant or falls pregnant, it is important that the GP or treating team closely monitors her health and the health of the unborn child.

Antidepressants are not usually very helpful in bipolar disorder. Women with bipolar disorder should avoid taking them on their own, as they can trigger highs or periods of

overactivity and euphoria that can be difficult to control. A regular routine and plenty of sleep are also important.

Other treatments

- Some women with very severe depression, including postnatal depression, benefit from electro-convulsive therapy (ECT). This is given in a hospital under a short-acting general anaesthetic, but might not need admission to hospital overnight.
- For SAD, light-box therapy (30 min to 1 h each day) or an antidepressant are effective.
- For premenstrual syndrome, antidepressants, vitamin B6 supplements, and the contraceptive pill can all help.

Tips for family and friends

- It is not easy supporting a loved one who has depression. It's normal to feel helpless, frustrated, angry, sad or guilty.
- Support the self-help tips for women with a mood disorder, above.
- Encourage her to see their family doctor. If she resists, suggest a simple check-up, and offer to go with her.
- Do not discourage her from taking medication or seeing a therapist.
- Spend time with her, and listen more than talking or advising.
- Don't say 'It's all in your head', 'You've nothing to be depressed about' or 'Pull yourself together'.
- Do say 'Your depression is real', 'I'm here' and 'You may not believe it, but you will feel better'.
- Don't hide their depression, or try to rescue or 'fix' them. It is not your fault and you can't make depression 'better'.
- Take it seriously if they get worse or talk about suicide. Make sure they tell their doctor.
- Don't take it personally if they say hurtful things.
- Take care of yourself – it is a necessity, not selfishness. You can only do so much.
- Talk to a friend or join a support group.

Staying well

Staying well depends on the three Ms: life management, mindset and medication. For women, good-quality relationships seem particularly important, whereas for men, success and achievement may protect against depression. Putting self-help approaches into practice is very useful.

For those prescribed antidepressants, it is important to continue them for 6 months or more. They are not addictive, although some women can find it hard to withdraw from them and need a very gradual reduction in dose. For repeated depression, medication can be taken safely for years (it halves the chances of the depression coming back).

Like Amanda at the start of this chapter, millions of women have overcome depression to lead happy and fulfilling lives again.

Useful resources

Depression Alliance
www.depressionalliance.org
0845 123 2320

Depression UK
www.depressionuk.org
0870 774 4320

Bipolar UK
www.bipolaruk.org.uk
0207 931 6480

National Association for Premenstrual Syndrome
www.pms.org.uk
0844 815 7311

Relate: The Relationship People
www.relate.org.uk
0300 100 1234

Samaritans
www.samaritans.org
08457 909090 (if suicidal or in crisis)

Cruse Bereavement Care
www.cruse.org.uk

Information on self-help practices
www.getselfhelp.co.uk

Free online CBT programmes for depression
www.livinglifetothefull.com
https://moodgym.anu.edu.au

Reading Well Books on Prescription
www.reading-well.org.uk
National reading scheme that lists self-help books for depression and other problems. Endorsed by professionals and supported by public libraries.

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CHAPTER 19

Anxiety disorders

Lynne Drummond

Linda's story

Linda is a 30-year-old nurse who works part-time and has two young children. Although always an anxious person, she began noticing that she was becoming more anxious about 3 years ago. At this time her eldest child started school and she had to take her baby to nursery, drop the oldest boy at school, and then go to work at a local health centre where she worked from 10[th]am to 2.30[th]pm. She found this rushing to several places stressful, and noticed she was finding it hard to concentrate because of her increasing anxiety: she was constantly worrying that she would not make it to either work or school on time.

Her husband noticed she was stressed and suggested she talk to her GP. Linda was reluctant at first as she felt she should be able to 'snap out of it', but eventually agreed. The GP agreed that she seemed very stressed and discussed treatment options with her. Linda did not want to take medication but agreed to a referral to the local psychological well-being service for a course of cognitive–behavioural therapy (CBT). Linda's GP also encouraged her to eat regular meals, avoid excessive caffeine drinks and alcohol and stop smoking, to help reduce her symptoms. The GP told her that regular exercise also helps some women overcome some of the symptoms of anxiety.

Linda started taking good care of her general health by eating well-balanced meals, reducing her alcohol consumption to no more than a small glass of wine on a maximum of 5 days a week, reducing her coffee drinking and joining a fitness club. She also went on a quit-smoking course and hasn't smoked for 6 months. Linda also attended five CBT sessions, in which the therapist helped her identify some of her 'trigger' thoughts – the ones that caused feelings of anxiety – and helped her deal with these thoughts, as well as exploring her ways of coping.

Linda now feels well and able to enjoy life. She admits

that she does become stressed and anxious at times but, instead of entering into a vicious circle of anxiety, worry and guilt, she knows she can examine the reasons why she feels stressed and try to work out the best possible solutions.

Every woman experiences anxiety at times in her life. In fact, if we were unable to experience fear and anxiety it would be very dangerous, as we would go into dangerous situations without thinking of the consequences. In addition, there are optimal levels of anxiety that help us to perform tasks. For example, a driver who has a healthy respect for the potential danger of the roads is likely to be a safer and better driver than someone who is overly confident (or very anxious).

The idea of 'clinical' or 'pathological' anxiety is a relative term. In other words, the anxiety is simply more frequent or more intense than the woman can tolerate. Women have traditionally been more willing to admit to anxiety, whereas men have been encouraged to hide their fears. Anxiety disorders include specific fears, which are called phobias, and more general fears in the form of generalised anxiety disorder and panic disorder.

Phobia

A phobia is an irrational fear of a situation or object that most women would consider non-threatening. Everyone has some irrational fears and dislikes, but a true phobia causes distress and interferes with normal day-to-day living.

Many phobias start in childhood or adolescence and can continue into adulthood. The types of phobias children have include fears of specific animals (e.g. dogs, cats, spiders), social situations or of performing certain acts such as eating or drinking in public, medical or dental procedures, and the sight of blood (known as blood and injury phobia). There are many other specific phobias, such as fears of thunder, heights or flying. A phobia that only occurs in children is school phobia or school refusal. This is quite common in anxious children, and while most fully recover, a few go on to develop agoraphobia or other anxiety problems later.

The most common phobia is agoraphobia. A woman with agoraphobia is anxious in crowded places such as public transport, busy supermarkets, and places where she feels she

cannot escape. Agoraphobia and specific animal phobias are more common in women than men, but social phobia, blood and injury phobia and miscellaneous specific phobias occur equally in women and men Agoraphobia usually starts in the twenties.

Generalised anxiety disorder

Generalised anxiety disorder refers to a more general experience of anxiety. All of us vary in the amount and intensity of anxiety we feel. Generalised anxiety disorder is diagnosed when there is a troublesome increase in anxiety that interferes with a woman getting on with her life. The widespread anxiety and worrying can be very debilitating. Generalised anxiety disorder is more common in women than men. It can also be part of a depressive illness.

Panic disorder

In this condition, the woman experiences extreme bouts of anxiety that often seem to come out of the blue. These bouts are accompanied by physical symptoms:

- difficulty breathing
- palpitations and feeling that the heart is beating too fast
- pins and needles in the fingers and toes
- a sense of impending death or that something terrible is going to happen.

These bouts sometimes happen in the middle of the night. Because these sorts of symptoms occur in some physical illnesses, many women have multiple medical tests before the diagnosis of panic disorder is made. These investigations are important but can, in themselves, raise anxiety. Panic disorder can occur alone or with agoraphobia and other anxiety disorders. Women are twice as likely as men to suffer from panic disorder.

Treatment

Cognitive–behavioural therapy (CBT) is the main psychological treatment for anxiety disorders. The therapeutic approach used

will depend on the nature of the specific problem.

CBT for phobia

For a phobic disorder, the woman and her therapist will work out a hierarchy of fear-provoking situations and, with the help of her therapist, the woman learns how to face these situations in a systematic manner. She will need to practice homework exercises regularly (at least twice a day) and for long enough each time for the anxiety to subside (usually an hour, at least initially). Once she has achieved the first steps on the hierarchy, the woman can move onto more difficult items until she covers the whole hierarchy. This treatment works for almost all women with phobias.

CBT for generalised anxiety disorder

For generalised anxiety disorders, CBT generally involves the woman and her therapist examining the thoughts that tend to precede anxiety episodes and piecing together evidence for or against these thoughts. The therapist will also give the woman practical exercises and assistance to overcome the symptoms of generalised anxiety.

CBT for panic disorder

For panic disorder, CBT might specifically focus on the catastrophic thoughts that women with this disorder often have. For example, the woman may notice her heart is beating faster than normal and might think, 'My heart is beating so fast, it will stop and I will die'. Having that thought will increase her anxiety and worsen her symptoms, reinforcing her belief that she might die. Therapy needs to break this connection using education and a number of practical experiments and tests, which the woman and her therapist can construct together.

Medication

Sometimes a selective serotonin-reuptake inhibitor (SSRI) is useful in the treatment of an anxiety disorder. These drugs are not addictive and the woman will need to take the SSRI regularly for some months (and sometimes longer); they are not effective if the woman only takes them when she feels as

though she needs extra help. It is best to gradually reduce and stop this medication with support from a GP to reduce the chance of any relapse.

Pitfalls to avoid are the use of alcohol to give 'Dutch courage' and the use of tranquillisers, such as benzodiazepine drugs like Valium. These drugs are addictive, so their use can lead to reliance and a need to increase the dose to get the same effect. Benzodiazepines should only ever be taken for less than 6 weeks at a time, and only under medical supervision.

Tips for family and friends

- Avoid judgement: a woman cannot 'snap out of' anxiety disorders and she is not being silly or melodramatic.
- It is important to encourage the woman to visit her GP. There are psychological therapy services in the community that the GP can help the woman to access for treatment.

Useful resources

Triumph over Phobia (TOP UK)
www.topuk.org
A self-help organisation offering self-help treatment groups for people suffering from phobia and OCD.

Anxiety UK
www.anxietyuk.org.uk
A self-help organisation that aims to offer support for those suffering from anxiety disorders.

NHS Choices
www.nhs.uk/conditions/anxiety
Information about anxiety disorders.

Eastham C (2016) *We're All Mad Here: The No-Nonsense Guide to Living with Social Anxiety*. Jessica Kingsley Publishers.

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