

# 'Are you okay?'

A clinical psychologist's account of having a daughter with depression, from Dr Annie Hickox



## **The call...**

I was cooking dinner one balmy, sweet-scented summer evening when our daughter Jane called me. Phone calls, particularly on the house phone, were not our two daughters' preferred form of communication. I was accustomed to long strings of WhatsApp messages, or even days of silence when Jane and her older sister Alice were busy with studies, work, or friends in London. I figured Jane was calling to discuss the plans they had made for their upcoming trip to work in the states over the summer. Sometimes a real-time discussion is best for fine-tuning and planning. After

her initial 'hello', I couldn't hear her voice. 'Are you okay?' I asked.

There was a broken pause and then: 'mum, I can't do anything'. I gently asked her what she meant, but my heart already ached with knowing.

## **The signs**

Jane spoke of sleepless nights punctuated by gothic nightmares, days without eating, and her fear of becoming physically sick if a friend dropped by unexpectedly. She would dart back and forth to classes

without stopping to speak to anyone, or even to buy food. Once classes and end-of-year projects wound down, so had her ability to function. Jane was running on empty. She described paralysing anxiety and a bottomless sense of failure. I recognised what many cognitive behavioural therapists refer to as ‘the tyranny of shoulds’. I should be able to go out, I should be feeling happy, I shouldn’t be like this, I shouldn’t be so afraid, so weak, so pathetic, so useless, so worthless. I should know what to do.

I recognised our normally resilient, spirited and sparkling girl was spinning like a wheel that dug itself deeper into the ground with each effortful turn. As a clinical psychologist, I recognised the classic signs of clinical depression and anxiety – the intense state of distress known as dysphoria, a term with Greek roots meaning ‘excessive pain’. I knew Jane needed to come home, now, and I knew she needed to see a doctor.

### Homecoming

I launched into practical mode and more or less commanded her to pack a bag and get a train from King’s Cross as soon as she could. I heard her soft voice, working its way through the fragile silence – and I knew she was crying. ‘Can I do that? Just come home?’

I explained she sounded as if she was suffering from depression and we could get her help. It made sense to come home, away from the pressures of day-to-day life, I told her. Another deep silence passed before she said ‘Okay, I’ll get ready’. Before we hung up, I said, ‘it’s going to be okay’, and hoped she couldn’t hear my voice faltering.

Over the following days, my husband John and I scrambled to decide what course would be best for our daughter. We created a mental flow chart of practical and personal approaches: a doctor, a diagnosis... maybe medication... definitely therapy, as well as an abundance of loving care, home comforts, a jumble of pets, and summer walks in the countryside where we live.

### Sanctuary

Although my initial urge was to protect her, to think of whatever things we could do to alleviate her pain, I also knew I could not be the one responsible for her diagnosis or therapy. I needed to let other professionals step in to help her navigate the clinical path of providing an initial assessment, and the guidance and therapy this would lead to.

I asked Jane if she wanted me to come with her to her appointment with our GP, but she chose to go into the consulting room by herself. Knowing how pressured GPs are, I sat in the waiting room wondering if her problems would be dismissed as a temporary reaction to a pressured time of year at University, or if the GP would recognise the signs of a mood disorder that appeared so conspicuous to me. Earlier that

year, Jane had been referred to an NHS counsellor for a number of sessions which had not been enough to uncover the deep undertow of depression that had been building up over time. Jane’s mental state continued to worsen, and she eventually became exhausted by the effort of hiding her symptoms.

After she emerged from the clinic room, it became clear that our family doctor was, quite literally, a lifesaver, confirming that Jane was experiencing a toxic mix of severe depression and anxiety; the most powerful, evidence-based intervention would combine both medication and therapy.

For Jane, the diagnosis was a signpost that she was no longer lost. Someone had been here before. The doctor would help dig her out of the avalanche of fear and helplessness. Our doctor, knowing I was a clinical psychologist, suggested a therapist based in London would be best for Jane in the long run. This way, she would hopefully be able to have longer stays in London as her mood gradually lifted, enabling her to get back to her social life and her older sister who would be able to support her.

These initial practical decisions were easy to deal with: I can remember sitting at my laptop and thinking, ‘Okay, this I can do!’. Over my many years as a clinical psychologist, I had built up a broad network of colleagues, enabling me to find a practice in London with highly qualified psychologists offering a range of approaches. I emailed the practice’s website link to Jane so that she could see which therapist she felt struck the right balance for her.

I thought it essential that she chose the therapist herself; I simply described the terms and therapeutic approaches when she asked. She was going to be going on the therapeutic journey by herself and I would not impose my preferences on her. I was very grateful that we not only had the means to afford private therapy but, thanks to my professional links, I was also able to access high quality therapy relatively quickly. Having worked in the NHS for decades, I knew that the process of referral, waiting lists, assessment, and then a further wait for therapy (if offered) can not only be painfully slow but also treacherous. It is often a highly unpredictable path, full of risks, and far too many people do not succeed in receiving the help that they deserve.

Before the day of her first therapy session, John and I thought of ways to provide as much stability and security we could, so Jane could start on her medication and catch up on sleep, food, and feeling safe. Over those first long days, I am sure that, to her, our voices sounded as though we were calling down to her in a deep, dark, empty well of despair. We didn’t push Jane to talk to us about how she was feeling, as it seemed that us just being there, available to connect with her in a small, consistent ways, would be of more value to her than the pressure of intimate discussions. Slowly, as her medication began to kick in, we saw tiny glimmers of light, and she recognised that some of the things I said to encourage her – even when I wasn’t

sure my hopeful words were well founded – made sense.

### First steps

As we drove Jane to the train station for her journey to her first therapy session, I fought back the urge to recite a litany of things to look for in a good therapist. I knew that I had to let go so that she could confide in someone outside of the loop – someone who would be able to listen to her objectively and empathically without mirroring her emotional pain. Watching her ascend the steps to the railway platform, John and I sat silently in the car, apprehensive about the risks of letting her leave the safe haven of home. She insisted on travelling alone and arranged for Alice to meet her at King's Cross and accompany her to the therapy clinic, and then meet up with her right afterward her session to take her back to the station.

That day, John and I discussed how we could support our daughter without undermining her autonomy. I was able to outline to him what my clinical experience taught me could be helpful, but we worked together to translate my clinical knowledge into practical measures that fit the informality of day to day life. I wanted him to feel hopeful and I knew I needed to try to contain my own self-doubt. I fought the urge to say yes, I am an expert, but not when it comes to my own daughter.

When we returned to the station to pick up Jane up that evening, our faces were frozen in apprehension while we waited for her train to arrive. As she came down the steps from the platform, we began to relax, simply because she had returned. As she climbed into the car with us, we hugged her and felt a sense of relief. We wanted to keep a watchful eye over her, without hovering, and we endeavoured to make sure she felt protected and cared for. That evening, we caught a fleeting glimpse of her smiling and realised how long it had been since we had seen her look happy.

Every day that summer we let Jane sleep late, knowing that her depression and the initial side effects of her medication would create havoc with her sleep pattern. We tried to introduce a bit of structure every day, even if it only meant going for a short walk, a short cycle, or a trip in the car. We eagerly indulged her with her favourite meals, films, books – whatever could create a sense of pleasure. All of the pets were allowed on the bed so that, during her wakeful nights, she knew she was safe and not alone.

### Side-effects

Over the next few weeks, as the tortured nightmares and daytime sleep began to fade, the low, muffled mood shifted into a vivid, but equally concerning, state of acute anxiety and fear. As the anxiety gripped her, the detailed information leaflet that came with



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her medication took on a ghoulish quality with its long lists of potential risks and side effects, ranging from the highly dramatic (the rare, but potentially life-threatening, serotonin syndrome) to the trivial (dry mouth).

Jane recognised her suffocating blanket of depression posed a greater threat than the temporary risks listed. In the first few weeks, a range of side effects ambushed her in subtle and startling ways. When I asked if she wanted to see her doctor to discuss her concerns, she said she figured that something powerful enough to shift her mood was likely to have effects that might feel strange, and even scary at times.

Every day Jane would throw me a volley of ‘what ifs’. What if I don’t get better? What if I stop eating? What if I lose control and harm myself even if I don’t want to? What if I want to have kids and suffer postnatal depression? What if I get worse? What if I always have this? What if this is as good as it gets?

I couldn’t answer these questions. Her eagerness for certainty resonated with the circular Socratic dialogue my husband and I would have when she was out of earshot. At times, the two of us engaged in a silent, almost telepathic, communication involving a semaphore of facial expressions, shrugs, and sighs to express our own congruence of fears, doubts, and hopes. I remembered having once read in a therapy book the value of saying, ‘The worst has already happened to you’. The first time I conveyed this to Jane, I don’t think she believed it. I wasn’t sure that I did, either, but the need to offer hope felt compelling.

At times, the teetering balance between overprotection and encouragement tilted too far on the side of caution, and it was Jane herself who set it right again. One afternoon, as she lay on the couch under a blanket, we peeked in on her and assumed she was sleeping. As we spoke quietly in the kitchen, John suggested that we shouldn’t make her go out for a walk with us, although she had agreed to it earlier. It was one of many moments when neither of us knew what to do. A while later, when I checked again to see if she was awake, she opened her eyes and said, ‘I heard you and dad talking about the walk. I need to be pushed. Don’t give up on me’.

### Flashbacks

Many families with a depressed child or adult often find that, for certain periods, all attention is focused on the one who is ill. Thoughts, behaviours, and emotions are magnetically drawn towards the suffering family member, subordinating all other family needs. Having grown up in a large family with a severely depressed father, I still recall how empty our busy house felt each day when he was ill. Our mother’s attention seemed completely focused on our father’s welfare. Not wanting this sense of emptiness to pervade our family, I knew that we had to be sensitive to the needs of Jane’s sister Alice, who no longer had Jane around as a sibling, friend, and confidante in London, and who

shared our worries and fears about Jane’s recovery. I made sure that we spoke on the phone regularly, and that we were always available to her. Our conversations were often punctuated by silences interspersed with her tears and sadness for her younger sister. Several times a day we would have surreptitious text conversations. I felt helpless about how to reassure or comfort Alice and realised how much we had always relied on her to be the strong older sister, so adept at pushing her own needs away in order to support her friends and, of course, Jane.

### Work-life balance

At work, my own negative chain of thoughts rattled in my head, following me everywhere – from my hospital clinics to the supermarket where I would buy Jane comforting foods and treats. I was plagued by a nonstop jackhammer of worry. I feared that if I confided in a colleague I would be told that, as a clinical psychologist, I should know what to do. Perhaps they don’t want to hear about it. They might doubt I can help patients if I can’t help my own daughter. They might blame me. Why wouldn’t they? And, worst of all, I feared being unable to perform my work because of my own personal crisis.

In the presence of colleagues, I felt ashamed that I had failed to prevent my own daughter from becoming depressed, and I feared being told that I wasn’t tackling it properly. With patients, I felt like a hypocrite, helping them move forward while Jane was sleeping the day away, after another sleepless night when she was jolted awake by nightmares and shadows and panic.

I had to find a way of navigating work while carrying a huge personal crisis around with me. I knew that I could and should confide in a few close colleagues, but my own sense of failure made me fear I would encounter a wall of shame. Somehow I should know what to do and I should be able to cope. Over the years my close colleagues and I have often discussed our shared professional emotional perfectionism, expecting ourselves to be able to sort out any personal crisis that hits us. We acknowledge the absurdity of this attitude, assuring one another we would always be mutually supportive; but in reality, when a major life event suddenly blindsides us, we ritually apologise to each other: ‘Sorry, this is stupid, I shouldn’t be so upset at work. I should be able to handle this. I’m just tired’.

We hide in the bathroom or in our parked car before we heading into the office, sobbing, overcome at our helplessness. We try to ‘fake it until we make it’, taking a deep breath and assuring others that we are ‘fine, really, absolutely fine – it’s okay’. We can get through a few hours and then something sets the tears off again. It might be someone inquiring kindly about how we are doing, or a patient who is struggling with a similar torment to the one we are trying desperately to stuff away into a compartment, at least during working

hours. We show up, even when we should stay away.

Over the following weeks, I found a narrow path to tread in the workplace. An approach/avoid response drew me to a few peers who had once opened up to me, and whom I had supported in the past. Trust was essential, as the slightest hint of judgement would confirm my sense of failure and weakness. I learned to avoid colleagues who unwittingly confirmed my own self-doubts and those who launched into therapy mode, trying to uncover the causes of my daughter's depression with what felt like a glaring spotlight on me. During the early days, I knew I might at any time need to go home to support Jane, or to simply look after myself. I knew that I had to tell my psychology manager about the situation, but the prospect of having to be so open about something so painful was daunting.

I was incredibly fortunate that my manager responded in both a human and professional manner. He said he was sorry to hear it, and that in these situations he always tells staff to take as much time as they need. I can still feel the relief of knowing there was a safety net just when my own grip felt most tenuous. I thanked him and walked away knowing that I was allowed to give Jane all the support she needed, and that it was also okay for me not to be stoic. My manager understood that in this situation there was no question that my family had to come first, and this new flexibility in my work schedule helped me cope. I had an escape route I could use, should I need it.

In my clinical work, I found that the degrees of separation between me and the difficulties of my patients and their families enabled me to maintain my objectivity and professional role, without my personal worries seeping into the clinical setting. Once I returned back to my office and shut the door, the painful surge of emotions returned. In a number of ways this experience has enhanced my clinical work. My empathy and understanding of depression and anxiety have a new depth only personal experience can provide. I recognise how the most fleeting glimmers of light can develop into rays of a lighter mood. I am more confident that the right therapy can work, and that igniting hope, even when tentative, is one of the most important steps early on in the path of recovery.

Throughout this crisis, and since, I often reflected upon the advantages that we were able to provide for our daughter. A major and constant strength was our close and supportive family and our ability to bring her back to the family home in which she had thrived while she was growing up. A further advantage was, perhaps paradoxically, my own family's multigenerational history of mental illness which enabled us to discuss Jane's psychological state with an ease, fluency, and a complete absence of shame or judgement that I know is unusual.

The most critical advantage, however, was my extensive professional experience and accumulated knowledge as a clinical psychologist. This gave me the ability to recognise and respond to the warning signs

of Jane's deteriorating mental health, and to use my professional network to find the optimum therapy for her.

### **Coming out of the darkness**

Though at times we felt like we were driving in the fog with headlights, only able to see what was right in front of us, over time we blazed a trail that would eventually become the path for Jane's recovery. As the summer progressed, we dared ask ourselves if she would be able to travel with us to a long awaited family wedding in the States (where I grew up) later that summer. There was certainly no pressure to do so – many people in my family, including me, had our fair share of mental health problems at some stage in our lives, and no one would judge Jane or pressure her to make a long transatlantic trip.

A further complication was Jane's new phobia of crowds, and her sense of claustrophobia on the London underground on which she had previously travelled effortlessly. The mere thought of approaching the escalator made her feel disoriented and sick. We had put the idea of travelling abroad on hold, but Jane had not given up on the wedding and saw the trip as a possible goal. Her trips down to London gradually grew from part of a day into a few days at a time. With Alice's constant support and advice, she started to see friends and even talked to a few of them about her experience of depression and anxiety. She gradually began to sleep regularly, eat meals, and feel hopeful that her depression was not permanent.

We began to breathe more easily, but it did not take much for us to hold our breath again. A sleepless night, or a new 'what if,' meant that even the good days felt delicate and raw. One day, Alice texted me to say they were going to just go into the entrance of the tube station to see how it felt. If Jane started to panic, they wouldn't go any farther. Although I wanted to support this venture, I worried about the possibility of a setback if Jane tried to do too much, too soon. I went off to work, doing a few hours of a clinic that morning, and giving myself permission to go home at lunch if I felt the need. My mind was distracted, focusing on all of the things that could go wrong, already thinking about how we would deal with a setback. During a break, I saw there was a text from Alice, with a photograph of Jane topping up her Oyster Card at the tube station. I started to text, 'Great, but, remember, if she starts to feel ...' and another photograph appeared. It was an image of Jane, smiling at the camera, as she went through the turnstile.

**Dr Annie Hickox** is a Chartered Psychologist/Consultant Clinical Neuropsychologist, with 35 years of clinical experience in the NHS & private practice. She is also a writer. Find her on Twitter @dranniehickox

*Dr Hickox obtained full consent from family members to share their story.*

## A postscript

Since *The Psychologist* published this article online, I have received many messages from people who found that it struck a chord. I have heard from fellow tweeters, professionals working not just in mental health, but also in medicine, nursing, and general practice. Students, parents, and a few of my own patients got in touch. Virtually all of them have said that they had gone through very similar experiences with a family member. They have told me their personal stories, detailing the suffering of a family member, their prolonged struggles in navigating the NHS and sometimes private treatment, and the sense of imposter syndrome that arises from being a parent who cares for patients during the day, but feels like a helpless novice when it comes to trying to support a young adult child. Hearing from complete strangers who took the time to contact me provided me with a poignant awareness that Jane's and my experience was shared and understood by so many people, including a few of my colleagues whom I had no idea had themselves been struggling alongside me.

After the initial flurry of tweets and private messages, I received an email from the producer of BBC Radio 4's *All in the Mind*, presented by Claudia Hammond, a psychologist whose programme delves into psychology and science every week. The thought of being interviewed on it was both thrilling and terrifying. I knew that I could not do it without Jane being fully on board, and her reply to my Whatsapp raising the issue summed it up, 'Nervous, but of course I want to, obv... Exciting!'

We both felt apprehensive about sharing such a personal experience on a programme that would get wide exposure, but we agreed that if it helped even a few listeners talk more openly to their families about mental health issues, then it was worth the risks. Meeting Claudia in the London studio, we felt at ease and knew that we could trust her with our story. Although we were discussing a very sad and painful time, she was such an empathic and sensitive listener that our conversation felt important and interesting.

Empathy and sensitivity. Also, in my view, the necessary qualities we hope to find when we take the risk of talking about our mental health issues. I consider the stages of talking about our mental health to be the initial anticipated risk of sharing, followed by the actual process of talking, and finally, the effect that it has on the listener and on us afterwards.

Jane describes the risk vividly, 'Depression is so vast, you feel so untouchable, you can't imagine anyone understanding it. It feels so lonely because the experience is so individual, and feels so uniquely personal, that I really believed no one could possibly know what I felt like. I also felt scared and superstitious that saying it out loud could actually make my symptoms/fears/depression even more real or worsen how I feel.'

I faced different challenges from Jane in describing my experience as a parent with a child suffering from depression. My emotional perfectionism, a characteristic that I believe to be common in our profession, provides the template for the bright and breezy persona I needed to project to my team as the professional lead of a specialist neuropsychology service. Most

of the time, this persona works well in our job, and is mirrored by our fellow colleagues. 'I'm absolutely fine, how are you?' punctuates the day, no matter how weary or vulnerable we may feel. The psychotherapist Lori Gottlieb describes psychologists as experiencing the need to be 'the most together person in the room', and our equilibrium can be both a reassurance and an anchor to the patients we are trying to help through life crises. In this environment, where our positive outward demeanour at times becomes a shield, broaching the subject of my personal distress about my daughter felt very risky and precipitous.

Like Jane, I dreaded that my most private, shaming thoughts would be confirmed and reflected back to me if I took the risk of opening up to my colleagues. I braced myself for a volley of 'shoulds' being fired at me as a mother and as a psychologist. I wondered if my upbeat facade would be forever compromised if others knew of my inner struggle and sense of fragility. At the opposite extreme was the fear that my deep concerns would be minimised as 'normal distress' with the implication that my emotional pain was minor, to be expected, and would be met with the unspoken message, 'pull yourself together'.

Gradually, I took the leap, telling myself that this was too important to contain, and that it was my story, as much a part of my identity as the 'positive attitude' that my colleagues considered so refreshing. I realised I could hold both of these at once: I could be a competent professional as well as someone experiencing a personal crisis. By giving myself permission to talk, I found that I strengthened my equilibrium rather than weakened it, and that it was also okay to have spells of disequilibrium. This is the advice I would have given to a colleague, but taking it myself was hard.

Similarly, Jane has described the effect of talking about her depression as 'opening up a mental health narrative within my friendship group. Everyone has their own intricate fears and anxieties and you begin to draw links between each other's overall experiences. The first time I gathered the courage to tell my best friend, she opened up about her own story. That would not have happened if I hadn't spoken up.'

Every shared story that we now hear from others comes with a deepened sense of trust. We both feel that it is okay to talk about not being okay, and it's actually okay to say that we feel like a complete mess at times. We ask each other, 'why isn't everyone talking about this all of the time?'. By writing and talking about our personal stories, we are able to bring what we most feared out of the dark and hold it up to the light.

Mental health cannot enter the conversation if we don't let it in. For me, I had to take down the barrier of 'I'm absolutely fine!'. For Jane, it was depression itself which made her feel it was impossible to initiate a dialogue. She had no script. 'I needed you to ask me if I was okay. People need to ask, and then they need to ask again later. And keep asking. Never give up asking. I still need you to ask'.

Virginia Woolf once wrote, 'Describing illness, language runs dry. There is nothing ready made'. We have to coin the words ourselves and write, and re-write, our own script.