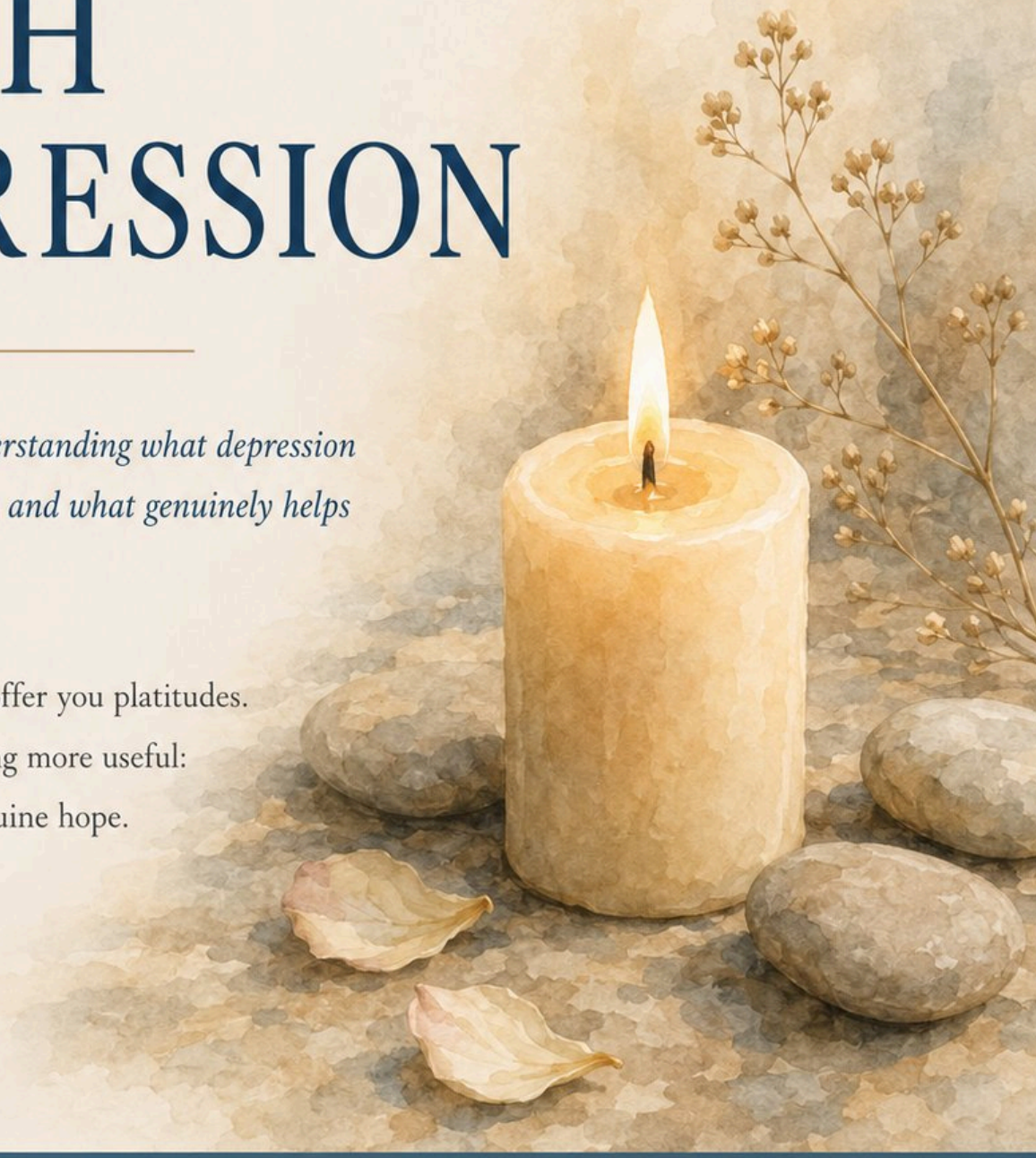
THE

LIVING WITH DEPRESSION

An honest guide to understanding what depression actually is, what it isn't, and what genuinely helps

This workbook will not offer you platitudes.
It will offer you something more useful:
honesty, clarity, and genuine hope.



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A note from Shelagh

I want to begin this workbook differently from the others in this series, because depression asks for a particular kind of directness.

Depression is serious. It is not a bad mood. It is not a character weakness. It is not the result of insufficient gratitude or inadequate effort. It is a condition that affects how the brain works — how it processes information, regulates emotion, generates motivation, and builds a sense of what is possible.

When someone is depressed, the very organ they would use to think their way out of it is the one most affected. This is not a metaphor. It is neuroscience. And understanding it changes everything about how we approach both the condition and the person living inside it.

In my own life, depression and I have had a long, and at times contentious, relationship. Looking back, I can see it was present far earlier than I had language for. As a child, I thought it was normal to dwell on things, to feel a kind of underlying melancholy, to let pessimism quietly shape how I moved through the world. It wasn't recognised as something separate from me. It simply felt like my way of being.

It was only later, in adulthood, that I began to understand it differently. A significant personal rupture — a failed marriage — became a tipping point that brought everything into sharper relief. What I had assumed was just part of my temperament revealed itself as something deeper and more enduring.

That period was profoundly dark. It was difficult to see any forward movement, any possibility — and harder still to describe the experience to anyone who had not lived it. The feelings were real, but language often felt too small to hold them.

Getting through it was neither linear nor quick. It took time, support, and an eventual willingness to stay in contact with experience that, at first, felt unbearable. I did come through it. And I hold a deep respect for what it took to get there.

One of the most important things I learned is this: what feels permanent in depression is not always permanent — even when it feels completely convincing in the moment. There is a way through, even if it cannot be seen from inside it.

In more than twenty years of practice, I have held space for depression in many forms. The person who cannot get out of bed. The person who gets up every day, goes to work, performs well, and comes home to sit alone in a flatness so complete they have forgotten what it felt like to want anything. The person who doesn't know they are depressed, because they have felt this way so long it seems like personality rather than illness. The person who knows exactly what is wrong and cannot shift it — which adds shame to the depression, and isolation to the shame, until the whole thing feels immovable.

One of the most important things to understand about depression is the way it shapes perception. It can convince you that things have always been this way and always will be. That you are beyond help. That trying is pointless, because nothing will change. That everyone else can cope and you cannot, and that this reflects some fundamental flaw in who you are.

None of this is objectively true. Yet from inside depression, it can feel entirely real, and entirely unquestionable. Part of healing is slowly learning to separate what depression is telling you from what is actually so. And that space — between the story depression creates and reality itself — is often where hope and recovery begin.

I am not going to tell you that exercise will fix it, or that a gratitude journal will lift the fog, or that you simply need to think more positively. Offered to someone in the depths of depression, those suggestions are not just unhelpful — they can be actively harmful, because when they don't work, they confirm the depressive story that the problem is you.

What I will offer instead is an honest account of what depression actually is, how it actually works, and what the evidence actually shows about what helps. Including, very importantly, when self-directed work is appropriate and when it is not — because one of the most important things I can do here is be clear that depression, particularly moderate to severe depression, often requires professional support, and that seeking it is not failure. It is the most sensible response to a serious condition.

If you are reading this in the depths of depression right now, I want you to know one thing above all else: the hopelessness you feel is a symptom. It is the depression speaking, not the truth. Things can change. People recover. The evidence for this is overwhelming. And you deserve to know it, even if you cannot yet believe it.

With warmth,

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How to use this workbook

This is a structured workbook, with space to write throughout. Depression affects concentration and motivation, which means reading and writing may feel harder than usual.

Please don't take that difficulty as evidence that this workbook isn't for you, or that you are too far gone for self-directed work to help. Work at whatever pace is available to you. A paragraph at a time is enough. A single exercise completed is enough. There is no correct speed.

If at any point what you read or write brings up thoughts of harming yourself, please stop and reach out — to someone you trust, to a crisis line, or to an emergency service. The final section lists support options. You do not have to manage this alone, and this workbook is not a substitute for professional care when professional care is what is needed.

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SECTION 1

What depression actually is

Neurologically, psychologically, and why it is not a choice

Depression is the most common mental health condition in the world. It affects an estimated 280 million people, and it cuts across every demographic, every culture, every level of external circumstance, and every degree of apparent strength or resilience.

It is also, despite how common it is, one of the most misunderstood conditions I know — misunderstood by the people around those who have it, and very often by the people who have it themselves.

Let me start with what it is not.

Depression is not sadness. Sadness is a natural human emotion — appropriate, proportionate, responsive to circumstances. It comes and it goes. Depression is something categorically different: a persistent alteration in mood, thinking, motivation, and physical functioning that is not simply a response to difficult circumstances, and that does not lift when circumstances improve.

This is one of the hardest things to explain to someone who has not experienced it: that depression does not work the way sadness works. It does not lift when good things happen. It is not a matter of trying harder, or thinking differently.

Depression is not weakness. It is not laziness. It is not ingratitude, self-indulgence, or a failure of willpower.

These characterisations are not only wrong — they are harmful, because they are so often taken in by the person with depression and added to the weight they are already carrying.

What depression actually is, neurologically

Depression involves measurable changes in how the brain is structured and how it functions. The prefrontal cortex — responsible for planning, decision-making, perspective, and the regulation of emotion — shows reduced activity. The amygdala, which processes threat and drives the stress response, tends toward heightened reactivity. The hippocampus, involved in memory and the processing of emotional experience, can be affected by the stress hormones that chronic depression produces.

The brain's reward system — the circuitry that generates pleasure, motivation, and anticipation — becomes significantly dysregulated. This is why anhedonia, the inability to feel pleasure in things that would normally provide it, is one of the hallmark features of depression.

Neurotransmitter systems are also affected — most notably serotonin, dopamine, and norepinephrine — though the relationship between neurotransmitter levels and depressive symptoms is far more complex than the simplified 'chemical imbalance' story that has dominated public understanding for decades. Depression is better understood as a systemic condition, involving neurological, immune,

hormonal, and psychological factors. That is part of why it responds to such a wide range of interventions — from medication to therapy to exercise to connection.

What depression actually is, psychologically

Psychologically, depression is marked by a particular style of thinking that tends to be pervasive, automatic, and very difficult to interrupt from the inside.

The cognitive triad described by the psychiatrist Aaron Beck — negative views of the self, the world, and the future — captures something essential about the depressive experience. Not just feeling bad, but perceiving, through a systematically distorted lens, that you are fundamentally inadequate, that the world is relentlessly difficult, and that nothing is going to improve.

This distortion is not a choice, and it cannot simply be corrected by positive thinking — partly because the thinking itself feels completely accurate when you are inside it, and partly because the neural pathways that would generate more balanced perspectives are precisely the ones depression compromises.

What this means in practice is that pulling yourself out of depression by thinking differently is genuinely difficult — and for many people, genuinely impossible without support. This is not a personal failing. It is the nature of the condition.

Exercise 1 What depression feels like for you

Your particular experience

Depression shows up differently in different people. For some, the dominant experience is profound sadness. For others, it is flatness — an absence of feeling rather than an overwhelming of it. For others still, it is mostly physical: exhaustion, heaviness, a body that feels like it is moving through water. For many it is some combination, shifting across days or even hours.

In your own words

Describe what depression feels like for you, as specifically and honestly as you can. Not what you think it should feel like, or what you have read that it feels like — your particular experience of it. Getting precise language for it is genuinely useful, both for your own understanding and for communicating it to the people who might support you.

Exercise 2 What depression tells you

Naming the messages

Make a list of the things depression tells you — about yourself, about the future, about whether things can change, about whether you deserve help. Write them down as statements, as directly as you can.

Naming the voice

Then, next to each one, write: this is depression speaking. Not because that immediately makes it feel untrue — it probably won't. But because beginning to identify the voice of depression as separate from your own voice is the first step toward not being entirely governed by it.

SECTION 2

The wide spectrum of depression

Including what gets missed

One of the reasons depression so often goes unidentified — sometimes for years — is that it presents across a very wide spectrum. The presentations that differ from the cultural image of depression — the person who cannot function, who is visibly sad, who has withdrawn completely — are frequently missed. By the people around them. By GPs. And by the person themselves.

The clinical criteria for a depressive episode include persistent low mood, or loss of interest or pleasure, present for at least two weeks, along with a range of other symptoms: changes in sleep, appetite, energy, concentration, and physical movement; feelings of worthlessness or excessive guilt; and, in more severe presentations, thoughts of death or suicide. A formal diagnosis requires that these symptoms cause significant distress or impairment.

But between the full clinical picture and simply having a hard time, there is a great deal of territory that deserves attention.

High-functioning depression

This is the presentation I want to address most directly, because it is the one most consistently missed — and most often suffered in silence.

High-functioning depression — sometimes called dysthymia in its chronic, lower-intensity form, or simply an unrecognised depressive episode in its more acute presentations — describes people who are managing. Who are producing. Who are showing up. And who are nonetheless living inside a persistent fog of flatness, low-grade despair, or joylessness that has become so familiar they have stopped registering it as abnormal.

These are people who go to work and do it well. Who parent, maintain friendships, meet obligations. Who, when asked how they are, say fine — and are believed, because the outside looks coherent. Inside, there is a relentless, low-level suffering that rarely breaks the surface dramatically enough to be named. It gets experienced as tiredness. As mild cynicism. As the sense that nothing is quite as enjoyable as it used to be. As a loss of colour from what was once a vivid life. It is often put down to stress, or busyness, or simply the reality of adult life. And years can pass.

I want to say this clearly: a life lived in that fog is not fine, even if you are functioning.

You deserve more than survival. And the fact that you are managing does not mean that what you are experiencing doesn't warrant attention.

Masked depression

Depression sometimes shows up mainly through physical symptoms — chronic pain, fatigue, digestive problems, frequent illness — or through behaviour, such as irritability, anger, risk-taking, or increased use of alcohol or other substances, rather than through the low mood most people associate with it.

This is particularly common in men, and in cultures where emotional expression is discouraged. When depression is masked this way, it is often treated as something else entirely — or not treated at all.

Seasonal patterns

Some people experience depression with a clear seasonal pattern — most commonly in the winter months, when light levels are low. This is clinically recognised as Seasonal Affective Disorder. If your low mood follows a consistent seasonal pattern, it is worth noting and worth discussing with a professional, because it has specific and effective treatments.

Exercise 3 How does depression show up for you?

Recognising your pattern

Reading the presentations above, which feels most like your own experience? Is what you are dealing with acute and clearly impairing, or more chronic and low-level — a persistent flatness you may not previously have connected to depression? Has it shown up mostly in mood, in physical symptoms, in behaviour, or in some combination? Being specific about your own presentation helps clarify what is actually happening, and what might help.

SECTION 3

Depression, anxiety and trauma

The connections that matter

Depression rarely travels alone. Understanding what accompanies it — and the relationships between depression, anxiety, and trauma — matters clinically, because it shapes both the experience and what is most likely to help.

Depression and anxiety

Depression and anxiety co-occur so frequently that some researchers have asked whether they are truly distinct conditions, or related expressions of the same underlying vulnerability. Living with both at once is one of the most exhausting and disorienting things I know — the flatness and withdrawal of depression coexisting with the agitation and hypervigilance of anxiety, sometimes within the same day, or even the same hour.

If you experience both, you are not unusual, and you are not facing two separate problems to be solved in sequence. They need to be understood together, because they interact: anxiety can drive the exhaustion and helplessness that feeds depression, and depression can lower the threshold for anxiety by wearing down the systems that would normally buffer it.

Depression and trauma

The relationship between trauma and depression is strong and well established. Traumatic experiences — whether single-incident, or chronic and developmental — alter the nervous system, the stress-response system, and our patterns of attachment in ways that significantly increase vulnerability to depression.

Unprocessed trauma frequently underlies depression that does not respond fully to standard treatments. This is one of the important reasons trauma-informed approaches have come to be seen as essential rather than supplementary.

If you have a history of adverse experiences — whether or not they meet the clinical threshold for trauma — and you are also depressed, it is worth considering whether the depression may have roots in that history that have not yet been adequately addressed. This is not about blaming the past, or using it as an explanation that forecloses agency. It is about seeing the full picture, so that what you reach for actually addresses what is actually there.

Depression and physical health

The relationship between depression and physical health runs in both directions. Depression increases vulnerability to a range of physical conditions — partly through its effects on the immune system, sleep, and health behaviours. And physical conditions, particularly chronic illness, chronic pain, neurological conditions, and hormonal disruption, significantly increase the risk of depression. If you are managing a physical health condition alongside depression, this two-way relationship is worth acknowledging, and worth raising with the clinicians supporting you.

Exercise 4 What travels with your depression?

Seeing the whole picture

Is anxiety part of your experience? If so, how do depression and anxiety interact for you — do they alternate, coexist, or seem to feed each other? Is there a history of difficult or traumatic experiences that you sense may be connected to your current depression, even if the connection isn't entirely clear? Are there physical health factors that feel relevant?

A gentle note

You are not trying to diagnose yourself or produce a clinical formulation. You are simply trying to see the whole picture, rather than one part of it.

SECTION 4

What the evidence shows about what helps

An honest account

This is the section I feel most strongly about, because it is where the most misinformation lives — and where that misinformation does the most harm.

The honest account is this: several things have good evidence behind them, most work better in combination than alone, and what helps any one person depends a great deal on the nature, severity, and underlying drivers of their particular depression. There is no single answer. There is also, genuinely, a great deal of hope — because depression is one of the most treatable conditions in mental health, and the treatments we have are effective.

Psychological therapy

Psychological therapy has a strong, well-replicated evidence base for depression. It is effective across a range of approaches, though different ones work better for different people and different presentations.

Cognitive Behavioural Therapy is the most extensively researched. It works with the relationship between thoughts, feelings, and behaviour — targeting the negative cognitive patterns that characterise depression, and building behavioural strategies that counteract withdrawal and inactivity. It is effective, particularly for mild to moderate depression, and its effects are durable.

Acceptance and Commitment Therapy offers a complementary approach. Rather than targeting the content of depressive thoughts, it focuses on changing your relationship to them — developing the capacity to hold them without being entirely governed by them, and orienting toward meaningful action even in the presence of difficult internal experience. For people who have found the cognitive component of CBT hard to engage with, ACT is often a more accessible entry point.

Internal Family Systems is particularly valuable when depression comes with strong self-critical patterns — when the inner critic is a significant feature. Understanding the depressive and self-critical parts of you as carrying specific burdens, and building a different relationship with them rather than simply trying to override them, can produce change that reaches below the level of thought into something more fundamental.

Compassionate Inquiry, and trauma-informed approaches more broadly, are essential when trauma underlies the depression — when the roots are in earlier experience that has not been fully processed. Standard CBT applied to trauma-rooted depression often produces only partial results, because it does not reach the level at which the difficulty actually lives.

Medication

Antidepressant medication has a genuine, well-established evidence base, particularly for moderate to severe depression. The evidence is clearest for more severe presentations; for mild depression, the benefit over placebo is more modest, which is why medication is generally not the first-line recommendation for mild episodes in the absence of other complicating factors.

I want to be direct about medication, because it is surrounded by significant stigma on one side and unrealistic expectations on the other. Antidepressants do not fix the underlying psychological or situational drivers of depression. They do not produce happiness. What they can do — for many people, not all — is reduce the intensity of symptoms enough to make the other work of recovery possible.

For someone in moderate to severe depression who cannot engage with therapy because the symptoms are too overwhelming, medication can be what makes engagement possible. Used in combination with therapy rather than instead of it, the evidence for both response and lasting recovery is stronger than for either alone.

If you are considering medication, the conversation is with your GP or a psychiatrist — not a decision to make from a workbook. What I want to offer here is permission to consider it without shame, and a realistic picture of what it can and cannot do.

Physical movement

The evidence for exercise as an intervention for depression is robust and consistent — stronger than most people realise. Regular aerobic exercise, around thirty minutes most days, produces effects on depressive symptoms comparable to antidepressant medication in mild to moderate depression. The mechanisms are multiple: direct effects on neurotransmitter systems, reduction of the inflammatory markers that are elevated in depression, improved sleep, and a reliable sense of agency and self-efficacy.

I want to be careful here, because 'just exercise' is one of the suggestions that can feel most invalidating to someone in the depths of depression, for whom getting out of bed is already an achievement. The evidence is real, and the recommendation is genuine. But it needs to be scaled to where you actually are. A ten-minute walk is better than nothing. Getting outside for five minutes is better than staying in. The goal is not a fitness programme. It is any degree of movement available to you right now, built on gradually as capacity allows.

Sleep

Depression and sleep have a two-way relationship: depression disrupts sleep, and disrupted sleep deepens depression. Protecting sleep — its regularity, its length, and the conditions that support it — is one of the highest-leverage things available in self-directed work, even when it is difficult. That means consistent sleep and wake times, limiting alcohol (which fragments sleep despite feeling sedating), reducing screens before bed, and creating conditions that support rest. None of this resolves depression. But chronic sleep deprivation reliably makes it worse, and any improvement in sleep tends to bring some improvement in mood.

Social connection

Depression drives withdrawal, and withdrawal deepens depression. The isolation it produces — both through the active withdrawal it generates, and through the shame that makes reaching out feel impossible — is one of its most self-sustaining features.

Maintaining some degree of connection, even when it feels effortful and even when the quality is limited by the depression itself, matters. Not large social engagements. Not performances of wellness.

Simply the presence of other people — the experience of being seen and not rejected, the co-regulation that human contact provides.

Lifestyle factors more broadly

Nutrition, alcohol reduction, time in nature, creative engagement, mindfulness practice — all of these have varying degrees of evidence as supportive factors. None is a cure. In combination, and alongside the more primary interventions of therapy, medication where appropriate, exercise, and connection, they contribute to the overall conditions of recovery. The difficulty is that depression systematically undermines the motivation for all of them — which is one of the important reasons self-directed work alone is often not enough for moderate to severe depression, and why professional support matters.

Exercise 5 What has helped, even a little?

Small anchors

Thinking about your own experience, what — if anything — has made even a small difference? Not necessarily resolved the depression, but shifted something, even temporarily? It might be a person, a place, a type of activity, a particular time of day when things are slightly easier. These small anchors are not trivial. They are evidence that the depression is not total, and they are worth identifying and protecting.

Exercise 6 What has got in the way?

Naming the obstacles

What has made it most difficult to reach for the things that help — or to seek support? Shame? The sense that it won't work? Practical barriers? The depression itself? Being honest about the specific obstacles is more useful than a general sense of being stuck, because specific obstacles can sometimes be specifically addressed.

SECTION 5

Finding meaning after depression

David Kessler and the sixth stage

Most people have heard of the five stages of grief described by Elisabeth Kübler-Ross — denial, anger, bargaining, depression, and acceptance. What fewer people know is that David Kessler, who co-authored two books with Kübler-Ross and worked alongside her for decades, came to believe the model was incomplete. In 2019, drawing on his own experience of devastating personal loss, he proposed a sixth stage: meaning.

I want to introduce this here — in a workbook about depression rather than grief — because the connection is closer than it might first appear. Depression and grief are not the same thing, but they share important territory. Depression frequently involves loss: of energy, of pleasure, of a previous self, of a life that was imagined. And the question Kessler's sixth stage poses — not what has happened to me, but what can I do with what has happened to me — is one of the most clinically useful questions available to anyone moving through, or out of, depression.

What the sixth stage actually means

Kessler is careful to clarify what meaning is not. It is not finding a silver lining. It is not toxic positivity dressed up as wisdom. It is not the suggestion that suffering was necessary, deserved, or secretly a gift. It does not require that what happened was okay, or that the loss was worth it.

Meaning, in his framing, is something you construct rather than discover — something you actively build in the aftermath of painful experience, rather than something that arrives ready-made. The distinction he draws is between what happened and what you do with what happened. The event itself — the depression, the loss, the difficult years — does not change. What can change is the relationship you have with it. Whether it becomes something that defines and diminishes you, or something that, over time and with the right support, informs and deepens you.

In practice, the move toward meaning tends to emerge naturally at a particular point in recovery — not forced, not manufactured, but genuinely available once enough healing has occurred. It cannot be rushed. Asking someone in the depths of depression to find meaning in their suffering is as unhelpful as any other form of premature positivity. But held lightly — as a horizon rather than an immediate demand — the question can become one of the most orienting things available as recovery progresses.

Meaning in the context of depression

For people who have lived through significant depression, the question of meaning can take several forms. Some find it in the quality of compassion they are now able to offer others who are suffering — not because they chose to suffer, but because suffering taught them something about the interior landscape of pain that cannot be learned any other way. Some find it in the clarity about what genuinely matters that often follows a period of profound difficulty. Some find it in the work itself — in deciding to do something with their experience, whether creative, relational, professional, or spiritual.

None of these is prescribed. The meaning that is genuine is the one that is yours — the one that emerges from honest reflection on your own particular experience, rather than from a cultural template of what recovery is supposed to look like. And meaning does not require that the depression is fully resolved before it can begin to form. Small seeds of it can take root even in the midst of recovery, and they can be part of what makes recovery possible.

Readiness and meaning — a note on timing

One of the most important things I have learned about the move toward meaning is that it cannot be willed. It requires a degree of readiness — an internal shift that happens in its own time, and that cannot be accelerated by effort or intention alone. Readiness is not the absence of pain. It is not the completion of grief or recovery. It is more like a subtle turning of orientation — a moment when the question of what is possible begins to feel more present than the question of how to survive what has already happened.

Recognising your own readiness — and distinguishing it from the pressure to be ready, which is something else entirely — is worth paying careful attention to. The pressure to move on, to find the lesson, to be grateful for the growth, is one of the things that can delay genuine meaning-making, by turning it into a performance rather than a real emergence. Readiness that is felt, rather than performed, tends to produce meaning that lasts. Meaning manufactured before readiness tends to collapse under the weight of what has not yet been fully felt.

Exercise 7 Where you are with meaning

No pressure to have arrived

Without any pressure to have arrived anywhere in particular — and with full permission to say that the question does not yet feel available — where are you in relation to meaning? Is there anything in your experience of depression that you have already begun to make sense of, or draw something from? Not because it was worth it, not because you would choose it again, but because something real and yours has emerged from it? Or is that question still too early — still more weight than resource?

Honestly

Write honestly. There is no correct answer here, and no timeline you are supposed to be on.

Exercise 8 What readiness feels like for you

Subtler than feeling better

Readiness to move forward — to begin building a life on the other side of depression rather than simply enduring it — is not the same as feeling better. It is subtler than that, and more personal. Have you noticed any moments, however brief, when the question of what is possible felt more present than the question of how to get through the day? Any small stirrings of curiosity, of wanting, of forward orientation — even if they were quickly overtaken again by the weight of the depression?

What would give it room

Write about what readiness feels like for you, or what you imagine it might feel like. What would need to be different — inside you, not in your circumstances — for readiness to have more room?

SECTION 6

Self-compassion

A different way of meeting yourself

Of all the relationships affected by depression, the one that tends to suffer most quietly is the relationship you have with yourself.

Depression is extraordinarily good at generating a prosecution of the self — a relentless inner commentary of failure, inadequacy, and not-enoughness. And here is the difficult part: that commentary feels like honesty. It feels like the accurate accounting of someone who has genuinely fallen short.

It is not.

It is depression taking real material — real events, real disappointments, real moments of falling short — and running it through a systematically distorted lens that strips out context, removes warmth, and turns the ordinary human record of imperfection into evidence of fundamental unworthiness. And the more harshly you treat yourself for being depressed, the deeper the depression tends to go. Self-criticism is not just a symptom of depression. It is one of its fuels.

This section is about a different way of meeting yourself. Not forcing yourself to feel positively, and not lowering your standards — but learning, slowly, to turn toward your own suffering with something other than judgement.

Self-compassion is the thread that runs through almost all of my work with depression. Over the years I have come to trust it more than almost anything else I do — not because it is gentle or pleasant, but because I have watched it shift things that nothing else could reach. When the harshness a person turns on themselves begins, even slightly, to soften, the depression itself tends to loosen its grip. I have seen this happen too many times to think it is coincidence.

The way I work with it draws on three things in particular: a self-compassion practice, a quality of compassionate inquiry, and an understanding of the different parts of us. I won't treat these as separate techniques here. In the room, they blend into a single stance — turning toward what hurts, with curiosity and warmth, rather than away from it in judgement. Let me share how I think about each, and why I have come to rely on them.

What self-compassion is not

I want to clear away some misunderstandings first, because they are the reason many people dismiss self-compassion before they have really tried it.

It is not self-pity. Self-pity narrows in on your own suffering and loses sight of everyone else's; self-compassion holds your suffering within the wider human experience of it. It is not self-indulgence, or letting yourself off the hook. It is not lowering your standards, or abandoning the things you care about. And it is not positive affirmations — in my experience, repeating kind phrases you don't believe tends to ring hollow, and can actually deepen the sense of being a fraud.

Self-compassion is simpler, and harder, than any of those. It is the willingness to be on your own side while you are suffering — to treat yourself with the same basic decency you would extend, almost without thinking, to someone you love. Almost everyone I work with can imagine offering that to a friend. The work is learning to turn it inward.

Turning toward the suffering

The first thing I usually invite is simply the willingness to notice that you are suffering, without either suppressing it or being completely swept away by it. In depression this is harder than it sounds, because the pain is so constant it stops being visible as pain and simply becomes the air you breathe. When I ask people to name it — this is suffering, this is a moment of real difficulty — something almost always softens, even slightly. That small act of turning toward is where it begins.

Then I try to widen the frame. Depression isolates. It whispers that everyone else is coping and you alone are failing. So much of the suffering I see is not the pain itself, but the conviction that the pain is proof of being uniquely broken. It is not. Struggling, falling short, and hurting are part of the shared human experience — 280 million people are living with this condition, and untold numbers have moved through it. You are not defective. You are a human being in pain, which is one of the most human things there is.

And then, the part people find hardest: actively offering yourself some warmth in the moment of difficulty, rather than the usual harshness. It can be a gentler tone turned inward. A hand placed on your own chest. A simple sentence — this is really hard right now, and I am going to be gentle with myself while I get through it. It can feel awkward at first. I promise you it becomes less so with practice.

When kindness toward yourself feels wrong

I want to prepare you for something I see again and again, because it surprises people and can make them give up too soon. For many who are depressed — and especially for those whose depression has roots in early experience — turning warmth toward themselves does not feel soothing at first. It feels uncomfortable. Sometimes it brings a wave of grief, or even a flare of the inner critic.

When this happens in my practice, I tell people directly: this is not a sign you are doing it wrong. Far more often, it is a sign you are reaching something that has needed this kindness for a very long time — and the system is not yet used to receiving it. So we go slowly. Small doses. The aim is never to feel wonderful. It is simply to practise not abandoning yourself, a little at a time, until warmth toward yourself stops feeling so foreign.

Understanding rather than judgement

The second strand of how I work is curiosity — the one thing the self-critical mind almost never offers itself. The shift I am always trying to make, with myself and with the people I see, is from what is wrong with me to what happened to me, and, gently, what am I carrying?

When the harsh inner voice is loud, the instinct is either to believe it or to argue with it. I have learned that there is a third option, and it is far more useful: get curious about it. Where did this voice learn to speak this way? What is the pain underneath it? I have found, consistently, that the self a person finds hardest to be kind to is almost always the self most in need of understanding.

This is not about excusing or minimising anything. It is about asking, slowly and honestly: what was I carrying at the time? What did I not yet know? What was I trying to protect, manage, or survive? What was the logic, however painful, of what I did? In my experience, this kind of inquiry reaches places that direct attempts to 'be kinder to yourself' simply cannot. It does not force kindness. It creates the conditions in which kindness becomes possible — and the warmth that grows out of genuine understanding is steadier, and far more felt, than anything willed into place.

The critic is a part, not the whole of you

The third strand is one I find people in depression often experience as a genuine relief: the recognition that the harsh inner critic, however cruel it sounds, is only one part of you. It is not the whole of you, and it is not the truth about you. When I can help someone hear it as a part — rather than as the verdict of reality — something important changes.

More than that: in my experience the critic is almost always a protector. However badly its strategy is misfiring, it is usually trying, in its own harsh way, to keep you safe — to make you perform, to pre-empt other people's judgement, to stop you being caught off guard. Underneath it, more often than not, is a younger, more vulnerable part carrying the real weight of the pain. And alongside all of these parts I have come to believe there is a steadier core in each of us — something naturally calm, curious, and compassionate, that is never destroyed by depression, only obscured by it. Part of my job is to help people find their way back to it.

The practical shift is this. When you can notice the critic as a part — 'a part of me is being very hard on me right now' — rather than being completely merged with it, a little space opens. From that space, you can turn toward the part with curiosity instead of obeying it or fighting it. You can ask what it is afraid would happen if it stopped. You can begin to meet the frightened part beneath it with the warmth it never reliably received. This is slow, careful work, and the deeper layers of it are often best done alongside a therapist — but I have seen even a first glimpse of it change the whole internal atmosphere.

Why I keep returning to this

These three strands meet in the same place. All of them turn toward suffering rather than away from it. All of them choose understanding over judgement. And all of them treat the harshest, most painful parts of your experience as deserving care rather than condemnation.

I want to be clear that this is not soft work, and it is not decoration on the 'real' work. It is the real work. Self-criticism actively feeds depression — I see it keeping people stuck every week — and the slow growth of self-compassion is, in my experience, one of the most reliable things that helps them get free of it. And it is learnable. It is a capacity, like any other, that strengthens with practice. Beginning to extend toward yourself the understanding you would offer someone you love is not self-indulgence, and it is not avoiding accountability. It is the beginning of putting down a weight that depression has been using to keep you down.

A place to begin

You do not need to feel self-compassionate in order to practise it — I reassure my clients, because there can be the assumption that the feeling has to come first. It doesn't. It begins in small moments. A slightly gentler tone when you notice the criticism starting. A pause to acknowledge that something is genuinely

hard before you move on. A hand on your own chest. The simple recognition that a part of you is struggling and could use some kindness rather than another verdict.

Not doing it perfectly. Just practising, in small ways, not abandoning yourself.

Exercise 9 The voice you turn on yourself

Noticing the critic

Spend a little time noticing the way you speak to yourself when things are hard. What does the critical voice say? What is its tone — cold, contemptuous, impatient, relentless? When does it tend to get loudest? Try writing down some of the things it actually says to you, in its own words.

Getting curious about it

Now, rather than believing it or arguing with it, get curious. If this voice is a part of you that is trying, in its harsh way, to protect you — what might it be afraid would happen if it went quiet? What is it trying to guard you against? And whose voice does it remind you of, if any?

The friend test

Finally: if someone you loved was suffering exactly as you are, would you speak to them in this voice? If not — what would you say to them instead? Write it down.

Exercise 10 A moment of self-compassion

A practice I often use

This is a short practice I come back to with people again and again, because it is simple enough to use in a difficult moment. You can do it in writing here, or quietly to yourself any time things feel hard. Bring to mind the difficulty you are carrying right now — you don't need the most intense version, just what is present.

Three movements

- *Name it honestly: "This is a moment of real suffering. This is hard right now."*
- *Widen it: "Suffering is part of being human. I am not the only one who feels this. I am not uniquely broken."*
- *Offer yourself something: a hand on your chest, and a phrase such as "may I be gentle with myself," or simply asking, "what do I most need to hear right now?" — and writing it down.*

If it feels uncomfortable

If warmth toward yourself brings resistance, grief, or 'I don't deserve this', please don't take that as a sign you are doing it wrong. In my experience it usually means you are reaching something tender that has needed this for a long time. Go gently, in small doses. You are not trying to feel wonderful. You are simply practising staying on your own side.

SECTION 7

Talking about it

And asking for what you need

One of the most isolating features of depression is how hard it is to tell other people about it. The shame. The fear of being a burden. The exhaustion of trying to explain something that has no obvious external cause. The worry about how it will change the way people see you. All of it conspires to keep depression private — in a way that deepens the very isolation it produces.

I want to offer some honest thinking about this, because the decision of whether and how to talk about depression is genuinely complicated — and the advice to simply 'reach out' or 'talk to someone' can feel frustratingly simple when the actual experience of doing so feels so fraught.

Choosing who to tell

Not everyone in your life needs to know, and not everyone will respond helpfully. Being thoughtful about who you tell — choosing people who have shown they can offer non-judgemental presence, who are unlikely to respond with alarm or unsolicited advice, and who can hold what you share without making it about themselves — is reasonable. You are not required to be universally open about a medical condition.

At the same time, depression's preference is for silence and secrecy, because isolation deepens it. Choosing at least one person to tell — even imperfectly, even partially — tends to produce relief that is disproportionate to how much was actually shared. The experience of being known, and not rejected, is itself therapeutic.

What to say

Many people find it helpful to be straightforward and specific rather than vague. Not 'I've been a bit down', but 'I've been struggling with depression and I wanted to tell you — not because I need you to fix anything, but because carrying it alone has been hard.'

Naming what you need — or what you don't need — helps. Most people, when they learn someone they care about is depressed, want to help but don't know how. Giving them something specific and manageable — come for a walk with me sometimes, check in by message now and then, just be normal with me — is genuinely useful.

When it is not received well

Sometimes people respond to disclosure of depression in ways that are unhelpful — with dismissiveness, with unsolicited advice, with their own discomfort in a way that makes it about them. This is painful, and it is not a reflection of the validity of what you are experiencing. It is a reflection of their discomfort with a subject our culture has not yet learned to hold well. If it happens, please don't let it close the door on telling anyone else.

Exercise 11 What has been unsaid

Bringing it into view

Is there something about your depression that you have not told anyone — or not told fully? What has made it difficult to say? And is there someone in your life who might be able to receive it, if you found a way to say it?

No pressure to act yet

You do not need to act on this immediately. But naming what has been unsaid, and why, is a useful starting point.

SECTION 8

Finding the right level of support

Understanding your options — from self-directed work to specialist care

I want to be more direct in this section than in the equivalent section of the other workbooks in this series, because depression specifically warrants it.

Self-directed work has a real and meaningful role in depression — but its appropriate scope is significantly narrower than for anxiety, burnout, or grief. This is not because people with depression are less capable of it. It is because the nature of depression — its effects on thinking, motivation, and the capacity for self-regulation — makes it a condition that genuinely and frequently requires professional support to address adequately. Self-directed work is most appropriate for mild symptoms, as a complement to professional support, and as a maintenance strategy during and after recovery. It is not an adequate stand-alone response to moderate or severe depression.

What you can do on your own

For mild depression — low mood that is present but not significantly impairing daily life, and that has been present for less than several months — the self-directed strategies in Section 4 are a reasonable starting point: structured physical movement, sleep protection, maintaining connection however imperfectly, reducing alcohol, and some form of daily reflective practice.

The exercises in this workbook — particularly naming what depression is telling you, and distinguishing its voice from your own — are useful complements to any level of professional support, and a meaningful starting point when symptoms are mild.

Be honest with yourself about whether what you are doing is working. If you have been trying self-directed approaches for six to eight weeks without meaningful improvement, or if the depression has been present for longer than two to three months, that is a signal that more support is needed. Not a signal that you have failed. A signal that the condition needs more than self-directed work can provide.

When a therapist can help

Therapy is appropriate for depression across a wide range of severity — from mild depression where you have insight and motivation but want more than self-directed work, to moderate depression that is significantly affecting relationships and functioning, to depression that coexists with anxiety, trauma, grief, or complex self-worth difficulties.

A good therapist working with depression is not simply providing a space to talk about how you feel. They are working actively with the cognitive patterns, the behavioural withdrawal, the underlying drivers, and the relational dimensions of the condition — in a way that is structured, evidence-based, and adapted to your particular presentation. The therapeutic relationship itself is part of the treatment: the experience of being genuinely known, consistently accompanied, and not judged is corrective in ways that go beyond any single technique.

For depression with trauma roots, the approach matters significantly. Methods that work mainly at the cognitive level may produce only partial results if the depression is rooted in early relational experience or unprocessed traumatic events. Trauma-informed approaches, Compassionate Inquiry, and IFS are particularly valuable in these presentations.

When a psychiatrist may be needed

Psychiatric assessment is appropriate — and I would say necessary — in several situations. When depression is moderate to severe and significantly impairing daily functioning. When depressive episodes are recurrent. When there are thoughts of suicide or self-harm. When depression has not responded adequately to therapy alone after a reasonable trial. And when there is significant diagnostic uncertainty — particularly when symptoms might suggest a bipolar spectrum condition, which requires a different treatment approach, and in which antidepressants alone can sometimes cause harm.

If you are having thoughts of suicide or self-harm, please do not manage this alone. Tell someone you trust. Contact a crisis line. Go to your nearest emergency department. In most countries, your GP can arrange urgent psychiatric assessment. These thoughts are a symptom of the depression, not a rational evaluation of your situation — and they deserve urgent professional attention.

A simple way to orient yourself

- Begin with self-directed work if symptoms are mild, recent, and not significantly impairing daily life — and you are willing to be honest about whether it is working.
- Consider therapy if depression has been present for more than two to three months; if it is significantly affecting your relationships, work, or daily functioning; if it coexists with anxiety, trauma, or significant self-worth difficulties; or if self-directed work has not produced meaningful improvement.
- Seek psychiatric assessment if depression is moderate to severe; if you are having thoughts of suicide or self-harm; if episodes are recurrent; if there is diagnostic uncertainty; or if therapy alone has not produced adequate improvement.
- Reach out immediately — to a trusted person, a crisis line, or an emergency service — if you are in acute distress or having thoughts of harming yourself.

Depression is treatable. That is not a platitude. It is one of the most well-supported facts in the mental health literature. The path through it is rarely quick and rarely simple, but it exists — and you do not have to find it alone.

About Shelagh MacFarlane, MSc

Shelagh MacFarlane is a Canadian-British counselling psychologist with more than 20 years in private practice. She has lived in Southeast Asia for 26 years and works with clients across the world via Zoom. Before retraining as a psychologist, Shelagh had a career as a professional orchestral violinist — an experience that shaped her understanding of performance, perfectionism, and the psychological cost of maintaining a composed exterior when the interior is anything but.

Her approach

Shelagh works integratively, drawing on Internal Family Systems (IFS), Acceptance and Commitment Therapy (ACT), Compassionate Inquiry (developed by Dr Gabor Maté), inner-child work, Gestalt techniques, and mindfulness-based approaches. She does not apply a single model to every person. The work is shaped by who you are, where you are, and what you need. She works with individuals, couples, and families. Her particular areas of focus include anxiety, burnout, life transitions, relationship difficulties, identity questions, expat mental health, and the long-term psychological effects of growing up or living between cultures.

Qualifications and background

— MSc Counselling Psychology — United Kingdom
— Counselling Diploma — Canada
— Registered member, British Columbia Psychological Association (BCPA)
— Certified Executive Coach
— Member, International Practitioners of Holistic Medicine (IPHM)
— Trained in Compassionate Inquiry (Dr Gabor Maté)
— Former crisis line counsellor, Befrienders Malaysia
— Volunteer counselling: Malaysian Cancer Society, All Women's Action Society, UNHCR (supporting Afghan and Myanmar refugees)
— Communications and life-skills training across Asia, Africa, and the United States

Get in touch

Shelagh offers a free 15-minute initial consultation by WhatsApp or video call — no obligation, no pressure. This is a chance to ask questions, get a sense of whether the fit feels right, and understand what working together might look like. Sessions are conducted by video call at times that work across time zones. All enquiries are handled personally by Shelagh and treated with complete discretion.

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Depression is not a character flaw.
It is not a choice.
This workbook will help you understand what it actually is — and what genuinely helps.

When we stop misunderstanding depression and start responding to it accurately — with the right information, the right support, and the compassion it deserves — something genuinely shifts. This workbook offers an honest, clinically grounded account of what depression is, how it works, and what the evidence actually shows about recovery.

INSIDE YOU'LL FIND:

- What depression actually is — neurologically and psychologically
- The wide spectrum of depression, including high-functioning presentations
- The connections between depression, anxiety and trauma
- What the evidence genuinely shows about what helps
- How to talk about depression — and ask for what you need
- When self-directed work is enough, and when professional support is needed

The hopelessness you feel is a symptom.
It is depression speaking, not the truth.
Things can change. People recover.
You deserve to know that — even if you cannot yet believe it.

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ISBN 978-1-999999-902-4