A GUIDE FOR FAMILY & LOVED ONES

Understanding Depression

Recognising what depression can feel like, offering support without pressure, responding to risk, and protecting the wellbeing of the person who is supporting too.

Depression is more than sadness

Depression can affect emotion, motivation, thinking, sleep, appetite, movement, concentration, relationships and a person's sense of future. Somebody may look as though they are 'doing nothing' while using enormous effort simply to get through the day. Support is most useful when it combines warmth with realistic encouragement, professional care and respect for the supporter's limits.

What depression can feel like from the inside

Depression may feel like sadness, but it can also feel like emptiness, numbness, heaviness, irritability or complete disconnection. Activities that once brought pleasure may feel flat. The person may know intellectually that people love them while emotionally feeling unwanted, burdensome or beyond help.

Thinking can slow. Decisions that once took seconds can feel exhausting. Concentration and memory may become poor. A shower, meal, phone call or short journey can require planning that others cannot see. This is one reason advice such as 'just get up and do something' can land as criticism rather than encouragement.

Loss of pleasure and motivation

Anhedonia is the reduced ability to experience pleasure or interest. The person may stop enjoying music, food, sex, hobbies, friends or achievements. Loved ones can interpret this as rejection: 'You used to enjoy being with us.' Try to separate the symptom from the relationship. Reduced pleasure does not automatically mean reduced love.

Motivation often follows action rather than appearing before it. Very small, achievable activities can sometimes help rebuild momentum. The aim is not to force happiness but to create gentle opportunities for routine, mastery, connection and movement.

Exhaustion and slowed functioning

Depression can produce profound fatigue even when somebody is sleeping for long periods. Others may sleep very little. Movement and speech can become slowed, or some people become agitated and unable to settle. Physical symptoms such as aches, headaches, digestive problems and reduced libido may accompany the emotional symptoms.

If fatigue or physical change is new or severe, encourage medical assessment. Depression can coexist with physical illness, medication effects, hormonal changes, anaemia, thyroid problems and other conditions that deserve attention.

Guilt, shame and feeling like a burden

The person may apologise constantly, believe they have ruined family life or interpret ordinary difficulties as proof that everybody would be better without them. Do not get trapped in an endless reassurance loop. Warmly challenge the conclusion and stay alert to risk: statements about being a burden can sometimes accompany suicidal thinking.

Try: 'I hear that you feel like a burden. I do not see you that way, and I am also concerned about how hopeless you sound. Are you thinking about hurting yourself or ending your life?'

Irritability and withdrawal

Depression is not always quiet sadness. Some people become short-tempered, intolerant of noise or easily overwhelmed. Others stop answering messages, cancel plans or spend long periods alone. Withdrawal may protect depleted energy, but prolonged isolation can deepen depression.

The family balancing act

The question is rarely **'Should I push or should I leave them alone?'** A better question is: **'What is the smallest amount of encouragement that keeps connection and functioning alive without turning support into pressure or conflict?'**

Should I let them stay in bed?

Rest can be necessary, particularly when somebody is exhausted or acutely unwell. But spending most of every day in bed can disturb sleep rhythms, reduce activity and increase isolation. Avoid turning the bedroom into a battleground. Instead, agree one or two achievable anchors: open the curtains, sit downstairs for ten minutes, shower, eat something, or walk to the garden.

If the person is barely eating or drinking, unable to attend to basic hygiene for a prolonged period, unable to get out of bed at all, confused, severely slowed or rapidly deteriorating, seek professional advice rather than treating it as a motivation problem.

Food, appetite and self-care

Appetite may decrease or increase. Offer simple, low-effort food without moralising. 'I've made some soup; would you like a small bowl?' is often easier than 'You need to eat properly.' If intake is very poor, weight is changing significantly or there are concerns about dehydration or an eating disorder, professional assessment is important.

Self-care can be broken into tiny steps: wash face, change clothes, brush teeth, sit in daylight. Celebrate effort rather than demanding a complete routine. Avoid infantilising an adult or doing everything indefinitely if they can participate.

How much should I encourage activity?

Behavioural activation is an evidence-based approach that helps people reconnect with activities linked to pleasure, routine or achievement. Family encouragement can borrow the principle without becoming therapy: make the step specific, small and optional. 'Would you walk to the end of the road with me?' is more manageable than 'You need more exercise.'

Do not measure success only by whether the person enjoyed the activity. In depression, pleasure can return slowly. Getting dressed, attending an appointment or sitting with family for ten minutes can be meaningful progress.

Communication when hope has disappeared

Avoid arguing that the person has 'nothing to be depressed about'. Depression can distort the ability to imagine change. You do not have to persuade them that life is wonderful. Try: 'I believe that right now you cannot see a way forward. We do not have to solve your whole life tonight. Let's work out the next hour.'

Listen before problem-solving. Ask, 'Do you want me to listen, help think through options, or just sit with you?' This reduces the exhausting cycle where one person offers solutions and the other feels increasingly misunderstood.

What not to say

Phrases such as 'snap out of it', 'other people have it worse', 'you have so much to be grateful for', 'you're being selfish' or 'you'd feel better if you tried harder' can increase shame. Equally, avoid promising that you can personally make everything better. Hope is strongest when it is connected to treatment, time, practical steps and a wider support system.

Partners and intimacy

Depression can reduce sexual desire, affection, conversation and emotional availability. Partners may feel lonely while physically beside the person. Talk about closeness without making sex a test of recovery. Non-sexual touch, shared television, a meal or brief walk can maintain connection if both people want it.

The partner's loneliness also matters. They are allowed to acknowledge grief, frustration and unmet needs without being accused of making the illness about themselves.

Parents, siblings, friends and children

Parents may become overprotective; siblings may feel overlooked; friends may stop asking after repeated cancellations. Keep invitations open without creating guilt. 'No pressure, but you're still included' can preserve connection.

Children need simple, age-appropriate explanations and predictable care. They should not be asked to cheer a parent up, monitor medication or carry responsibility for suicide risk. Another dependable adult may be needed when depression is severe.

When everything feels impossible

Agree a minimum-day plan: **drink; essential medication as prescribed; something to eat; daylight; wash or change clothes if possible; one brief human contact; one tiny task; one period of rest; and the agreed action if suicidal thoughts increase.** Minimum days are about keeping a thread of life going, not achieving normal productivity.

Treatment and professional support

Treatment depends on severity, duration, previous episodes, preferences, physical health and other conditions. Psychological therapies and antidepressant medication are common options, and some people benefit from a combination. NHS services may include GP care and NHS Talking Therapies, with specialist mental-health services for more severe or complex presentations.

Talking therapies

CBT can help identify patterns between thoughts, feelings and behaviour and develop more helpful responses. Behavioural activation focuses particularly on the link between activity and mood. Other therapies may be appropriate depending on the person's needs, history and preferences. Treatment should be collaborative rather than something family members impose.

Medication

Antidepressants can help some people, particularly in moderate or severe depression or where psychological treatment alone has not been sufficient. Benefits may take time, and side effects vary. Medication should be reviewed with the prescriber. Families should not alter doses, share medication or encourage sudden stopping.

If mood worsens markedly after starting or changing medication, or suicidal thinking, agitation or unusual behaviour emerges, seek prompt clinical advice. Any immediate danger requires urgent help.

Recovery and relapse prevention

Recovery can be gradual. Sleep, appetite or concentration may improve before pleasure and confidence return. A person may look better before they feel secure. Avoid assuming that one good day means treatment is finished or one bad day means everything has failed.

When the person is improving, identify their early warning signs: withdrawing, cancelling plans, staying in bed longer, stopping meals, increasing alcohol use, becoming unusually self-critical or losing interest in routines. Agree what the family should say and when professional help should be contacted.

Work, money and practical pressures

Depression can affect attendance, concentration and decision-making. Occupational-health input, temporary adjustments or phased return may help. Financial pressure can worsen hopelessness, so practical debt or benefits advice may be as important as emotional support. Supporters should avoid taking on unaffordable debt to keep everything looking normal.

Alcohol and drugs

Alcohol or drugs may be used to numb distress or help sleep, but they can worsen mood, sleep quality, impulsivity and suicide risk. Approach the subject without shame and seek specialist help when substance use is becoming part of the problem.

Suicidal thoughts: ask directly

If somebody says they are a burden, there is no point, people would be better without them, or they wish they would not wake up, ask directly about suicide. Questions such as 'Are you thinking about ending your life?' and 'Have you thought about how you would do it?' help clarify risk; they do not create suicidal ideas.

Listen calmly. Do not react with anger, guilt or 'How could you do that to us?' If there is a plan, intent, access to means, recent attempt, severe intoxication, inability to stay safe or another immediate danger, seek urgent or emergency help. Do not promise secrecy.

A family member cannot guarantee another person's safety

You can care deeply, remove yourself from immediate danger, encourage help, follow a safety plan and involve professionals. You cannot watch another adult every minute or make yourself solely responsible for whether they live. A crisis plan should include professional contacts and clear thresholds for escalation.

Suicide-safety principle

Take suicidal communication seriously, ask clearly, stay calm, reduce immediate danger where you can do so safely, and **bring in professional help rather than turning one relative into a 24-hour crisis service.**

Safeguarding yourself as a supporter

Depression can quietly reorganise a household. One person may take over cooking, cleaning, childcare, finances, appointments and emotional support while also working and worrying about suicide risk. Because the illness looks passive rather than dramatic, supporter burnout can go unnoticed for months.

You may feel resentment and then shame for feeling resentful. You may miss companionship or intimacy. You may become afraid to leave the house in case something happens. These experiences deserve support; they do not cancel your care for the person.

Support versus rescue

Support makes tasks possible: sitting beside someone while they call the GP, making a simple meal, walking together, helping organise an appointment. Rescue gradually takes over every responsibility, hides consequences, cancels the supporter's life and teaches everyone that the depressed person can do nothing.

As recovery begins, hand manageable responsibilities back. Autonomy is part of recovery. The exact pace depends on severity and safety, but the direction should usually be towards greater participation rather than permanent dependence.

Boundaries are compatible with kindness

Examples include: 'I can listen for half an hour, then I need sleep.' 'I can help with this form, but I cannot complete every application for you.' 'I will take suicidal thoughts seriously and involve professionals.' 'I need one evening each week for myself.' 'I care about you, and I cannot be the only person you speak to.'

Do not use boundaries as punishment or withdraw care to force recovery. Make them predictable, realistic and focused on what you will do.

Carer fatigue

Warning signs include sleep problems, dread, irritability, loss of concentration, cancelling your own appointments, feeling guilty when you enjoy yourself, checking constantly, becoming socially isolated or believing that your own needs are selfish. If you recognise these signs, widen the support system.

Your own mental health

Partners and relatives can experience anxiety, depression or secondary distress themselves. Counselling, carers' support, trusted friends and GP support can provide a place where you do not have to protect the depressed person from your feelings.

Children and safeguarding

If children are living with severe depression, maintain routines and ensure another adult can reliably meet their needs. Children should not be exposed to graphic suicide discussion or made responsible for keeping a parent alive. If caregiving, supervision or safety is compromised, seek appropriate professional help.

When urgent help is needed

Seek urgent help for suicidal intent or planning, a suicide attempt, serious self-harm, inability to eat or drink adequately, severe self-neglect, psychotic symptoms, extreme agitation, catatonic or near-unresponsive behaviour, or rapid deterioration. If there is immediate danger to life, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow any existing crisis-team plan. Samaritans can be contacted on 116 123 in the UK and ROI.

Supporter check-in

Ask: **Am I safe? Am I sleeping? Do I still have a life outside caring? Am I carrying tasks the person could begin to reclaim? Am I frightened to leave them alone? Are children affected? Who knows how difficult this has become for me? What support needs adding now?**

Practical family coaching tools

1. Minimum-day plan. Decide the smallest realistic anchors for a very low day: drink, food, medication as prescribed, daylight, basic hygiene, one contact and the crisis step if risk rises.

2. Gentle activity ladder. Write five activities from easiest to hardest. Example: sit by an open window; shower; walk to the gate; ten-minute walk; coffee with a trusted person. Start below the level that feels overwhelming.

3. Listen-or-solve prompt. Ask: 'Do you need me to listen, help you think, help you do something practical, or simply stay nearby?' This prevents unwanted advice from replacing connection.

4. Relapse signature. My earliest signs are ____. Changes in sleep are ____. I start withdrawing from ____. My thinking sounds like ____. The person I want to notice is ____. If these signs last ____, I want us to contact ____.

5. Supporter boundary plan. I can... / I cannot... / My protected time is... / I need help with... / If suicide risk rises I will... / The responsibility that belongs to professionals is...

6. Recovery evidence. Depression tells me nothing is changing. Evidence of movement might be: getting dressed more often, eating more regularly, answering one message, laughing briefly, attending treatment, sleeping more consistently or completing one task. Track function as well as mood.

7. Relationship check-in. What has depression been like for you? What has it been like for me? What support is helping? What is creating resentment? What ordinary part of our relationship do we want to bring back this week?

Common myths

'Depression is just sadness.' It can involve numbness, cognitive slowing, irritability and profound physical exhaustion. **'They would recover if they tried harder.'** Effort is often present but invisible. **'Family should do everything until they are better.'** Support should preserve or rebuild autonomy. **'Talking about suicide puts the idea in someone's head.'** Asking directly is an important part of responding safely. **'One good day means they are cured.'** Recovery is usually more gradual.

Recommended reading

Overcoming Depression - Paul Gilbert: a CBT-informed self-help resource. **Reasons to Stay Alive** - Matt Haig: a personal account that some readers find hopeful, though it is not a clinical manual. **The Noonday Demon** - Andrew Solomon: a broad exploration of depression through personal experience, culture and research. Choose reading according to the person's capacity; during severe depression even a short page can feel demanding.

UK resources and clinical sources

Useful UK starting points include NHS information on clinical depression and treatment, NICE guideline NG222 on depression in adults, NHS Talking Therapies, Mind information on depression, and Samaritans for emotional support. Local crisis and community mental-health arrangements vary by area.

Clinical note

This guide is educational and does not diagnose depression or replace individual medical or psychological advice. Depression can coexist with bipolar disorder, trauma, substance use, neurodevelopmental differences and physical illness. New, severe or unusual symptoms require appropriate assessment, and significant suicide risk requires urgent professional support.

A message from Maggie

Depression can be difficult to understand from the outside because so much of the effort is invisible. You may see somebody lying in bed, not answering messages or saying no to things they once loved. What you cannot always see is the weight behind those small actions - the thinking, exhaustion and hopelessness that can make getting through an ordinary day feel enormous.

If you love somebody who is depressed, you may find yourself trying everything. Encouraging, reassuring, cooking, organising, sitting beside them, making appointments and watching for signs that they are becoming less safe. Sometimes you will get it right and sometimes your help will be rejected. That does not mean you have failed.

Try to make support small and possible. A drink. A shower. Ten minutes outside. One phone call. Sitting together without needing to fix anything. Recovery is often built from ordinary actions long before the person feels hopeful enough to believe they matter.

And please remember that you matter too. You can love someone and still feel tired. You can understand depression and still miss your partner, parent, child, sibling or friend. You can offer support without giving up every part of your own life. You are not supposed to become the treatment plan or the only thing standing between another person and crisis.

Hope does not always need to sound like 'everything will be fine'. Sometimes hope is simply: 'We do not have to solve everything today. We will deal with the next part, and we will bring in more help when we need it.' My hope is that this guide helps both of you find a little more room to breathe while recovery develops.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

What would change if the family measured support not by **'Did I make them feel better today?'** but by **'Did we keep connection, safety, treatment and one small piece of life moving in the right direction - without losing the supporter too?'**