

depression

keeping hope alive

A guide for families & friends



Dr Patrick McKeon
Julie Healy
Geraldine Bailey
and Gerry Ward

Depression

Keeping hope alive

A guide for families & friends

Series Editor: Dr. Patrick McKeon

DEPRESSION



*Depression is like a big hole,
You are all by yourself without a soul
You are all upset
You are all scared
You feel as if no-one cared
You feel upset
You feel bad
You feel worried
You feel sad
You feel like everything is in a flurry
It is like one big worry*

Bridget Cantwell Aged 11

Contents

| | |
|--|----|
| Preface | 2 |
| Introduction | 3 |
| Part I | |
| What is a Depressive Illness? | 4 |
| Depression: Signs and Symptoms | 5 |
| How Common is it? | 6 |
| Are There Different Types of Depression? | 7 |
| Bipolar Disorder | 8 |
| Elation or Mania: Signs and Symptoms | 9 |
| What Causes Depression? | 9 |
| Depression in Children | 11 |
| Treatment | 14 |
| Part II | |
| Your Role as a Relative or Friend | 18 |
| Why the Divide | 20 |
| How Families React to Mood Disorder | 22 |
| Effect of Mood Disorders on Children | 23 |
| Advice for Relatives and Friends | 24 |
| Glossary of Terms | 32 |
| Suggestions for Further Reading | 37 |

Preface

If somebody close to you has become depressed, you will know by now that this is not a trivial condition. As illnesses go, it is under rated by those who have not experienced it, under reported by those who are in its grip, and because of these factors and others it is significantly under treated. Yet, one in three people have a full-blown depressive episode at some stage in their lives. In reality few, if any, people go through the different stages of life without some experience of depression.

The pages which follow, will give you an understanding of depression, what it is, why it occurs, and how it can be treated. More importantly, it sets out how you can gain an understanding of depression, so that you can both help the person about whom you are concerned and experience less worry and uncertainty. We would hope that on reading this you would have an understanding of how you can keep hope alive until the mood disorder has been successfully treated.

Introduction

You may be surprised to be reading this booklet and may never have thought that somebody close to you would get so depressed, but then they probably never thought so either. It catches a lot of people by surprise. Currently there are 300,000 Irish people, or 1 in every 14, who have depression. In the course of the average lifetime, there is a one in three chance of having a full-blown depressive episode and a further third will have lesser degrees of depression. So, depression is common.

Depression affects a person's thinking, feeling, and behaviour. It is an illness in the sense that it is disabling and beyond the person's coping ability. For most who experience it, they describe it as one of the worst things that ever happened to them. For some, as they grapple to find words to convey the horror they have been through, it seems more devastating than losing a close family member or of facing death with cancer.

For you as a relative or friend of somebody with depression, it is also devastating. At times, you will feel bewildered, upset, frustrated, agitated, or downright dejected. I hope that you will find within the pages which follow, that depression can be mastered. Knowing how to recognise it, the subtlety of its signs and symptoms, how it should be treated and what you might expect in terms of its future course will enable this mastery. But knowledge alone is not sufficient. Having gained this knowledge you must address your own feelings about depression and how it has affected your life. This you can best do by working in partnership with the person who is depressed and the treating doctor or therapist. Depression, as a disorder of emotions, affects those to whom the person is bonded emotionally. If that person is you, you have an important part to play in aiding that person's recovery.

PART I

What is a depressive illness?

A depressive illness is a disabling, overpowering experience affecting thinking and the way a person feels, disturbing sleep, appetite, and energy. At some level, the person feels unable to cope. It is useful to distinguish it from normal depression, that is, the ups and downs of every day life. These normal shifts of mood are relatively mild and tolerable and we can cope with them. When depression is more prolonged and/or intense, such that it is beyond the person's ability to function normally, it is referred to as a depressive illness. Clinical depression is an alternative term, simply meaning that it is sufficiently disruptive to warrant getting clinical or medical help.

Recognising Depression:

You don't have to feel depressed to be depressed

Depression frequently goes unrecognised for a variety of reasons. For one, in its early stages, it is so like a normal depression that it merges imperceptibly with it, so that it can be hard for the person to see the gradual deterioration in mood. Another explanation is that the person often does not feel depressed, but is mainly aware of tiredness, disturbed sleep, poor concentration or memory or reduced appetite. Indeed, tiredness, wakening during the night, being anxious and apathetic are the more common early symptoms. It is often only when the depression is more advanced that the person will actually feel depressed. So, it is useful to think of most depressions going through different stages of severity. In the mild stage, anxiety, self-doubt, poor concentration and tiredness are the main symptoms. In a moderate depression, feelings of bleakness, depression, guilt, loss of interest and general slowing of thinking are more evident. In both mild and moderate forms, the symptoms listed are often more evident in the morning and lessen or have disappeared in the evening. A severe depression is characterised by a worsening of the features of a moderate depression resulting in

slowness of walking, being quiet or withdrawn even to the point of being mute, being unable to eat, wash or dress. In addition, delusional beliefs or false ideas, such as believing one is bankrupt, terminally ill or has done some serious wrong, can be a feature of severe depression. Hallucinations, that is hearing voices or having visions, can also occasionally occur and they usually concern the same negative and guilt-ridden topics as in depressive delusions.

It is vital to realise that although you may observe these different stages of severity, the person who is experiencing them can often feel just as distressed in a mild depression, when they do not necessarily look depressed, as in a moderate depression, when you and others can see quite clearly that the person is unwell. It is particularly important to be aware of this as the person is recovering, when they move from a severe or moderate depression to a milder form. In the latter, they may look well but still feel miserable. You may think they have recovered as they appear brighter, but it is often at this stage that the person has a higher risk of suicide.

Depression: Signs and Symptoms

- Fatigue that is not relieved by rest
- Anxiety about trivial matters that previously were not of concern
- Feeling sad, depressed, empty or bored
- Poor concentration and memory
- Loss of interest in sex, hobbies, personal appearance, work, religion or whatever previously was of particular interest to the person
- Indecision
- Social withdrawal due to self-consciousness, loss of interest and quietness
- Slowing of thinking, speech and activity or restlessness in those who have an anxious pre-illness personality
- Sleep disturbance - difficulty in getting to sleep, waking repeatedly during the night or very early in the morning. Despite these complaints they may have been observed to have slept well

- Oversleeping which can often be combined with a broken sleep pattern or early morning waking
- Increased or diminished appetite
- Feelings of guilt, worthlessness or inadequacy
- Headaches, chest, abdominal or back pains with no physical basis
- Suicidal thoughts, recurring thoughts or dreams of death
- Delusions and/or hallucinations

If a person has feelings of anxiety or depression and 4 or more of the above symptoms for longer than two weeks, they meet the diagnostic criteria for Major Depression (set out by the Diagnostic and Statistical Manual - DSM IV) and they should seek medical help.

How common is it?

About 7% of the population have a clinical depression at any point in time. Women are 3 to 4 times more likely than men to have depression. Surveys show that depression occurs more frequently during the teenage years and in old age. These stages of life and after childbirth are times of major change in levels of sex hormones and in relationships, expectations, and outlooks. While 70% of women will have a mild short-lived or a 'normal' shift in mood following the birth of a baby, 5-10% of women will have a disabling post-natal depression.

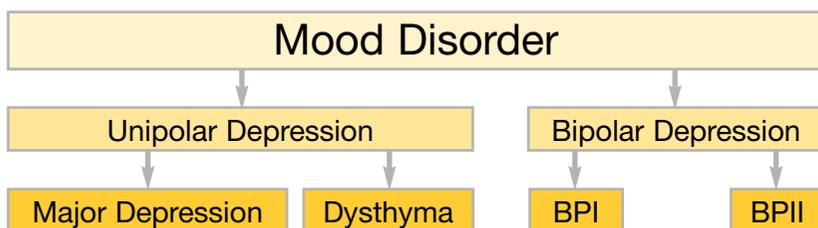
There is evidence to suggest that the mild to moderate forms of depression are on the increase, but the more severe biological depression, such as manic depression, also known as bipolar disorder, have not altered in frequency over the years. In addition, for the more severe depressions it is likely that there is no difference in the rate of occurrence between the sexes.

Depression is one of the most under diagnosed and under treated illnesses. Of every 4 people with depression in the community, only 2 will seek help and of those, only one will get adequate treatment. This means that only 25% of people with a disabling and potentially fatal condition get the appropriate help.

Are there different types of depression?

There are many different forms of depression, but as we do not fully understand how the different factors causing depression interact or exactly what happens in the brain, there are several different ways of classifying it. These methods have changed over the years.

Currently the most favoured way of classifying depression is to do so according to the pattern of occurrence of the signs and symptoms.



In the diagram above, mood disorder is divided into unipolar and bipolar disorder. Mood swings can be represented as swinging down at one end of the mood spectrum, the low pole, and up to the other end of the spectrum in Bipolar disorder. Hence “uni” refers to “one” pole or form of depression. We already referred to major depression, where the features of depression are present for longer than 2 weeks. This can further be divided into a single episode or a recurring pattern of depression. Disthymia refers to an ongoing low-grade depression, often lasting longer than 2 years. Bipolar disorder can be further subdivided into bipolar I disorder, where there are two poles, a depression and elation or mania, where the mania is of a severe, disabling nature. Under DSM - IV criteria, the features of mania need to be present for at least one week to be categorised as bipolar I disorder. In bipolar II disorder there are episodes of depression alternating with bouts of mania of a lesser degree, referred to as hypomania, where the signs and symptoms are present for four or more days. Both unipolar and bipolar mood disorder tend to recur as 70% or more patients can expect further episode. When the recurrence of mood disorder is particularly frequent, with 4 or more episodes per year, it is referred to as a rapid cycling mood disorder.

Another way of classifying depression is on the basis of the principal cause of the depressive episode. Reactive depression is purely an understandable reaction to a significant loss and the symptoms are of anxiousness, sadness, tension, irritability, feeling worse in the evenings, and having trouble getting to sleep at night. Reactive depression is the usual initial response to loss and it is the same as grief. It is important to realise the symptoms and signs of endogenous depression, which I will describe next, are not present.

Endogeneous depression is due to internal biological factors and frequently occurs after little or no stress. It has its symptom profile, fatigue, emotional deadness, broken sleep pattern or early morning wakening, tending to feel worse in the morning, and a progressive loss of interest in food, sex, or in whatever was of particular interest to the individual. Where stress or a loss has precipitated the first episode of endogeneous depression, it tends to be less important as a trigger for subsequent recurrences.

A personality based or neurotic depression refers to depression that occurs as a result of the way the individual is coping with life's problems. If an individual has difficulty asserting themselves, is extremely perfectionistic or rigid in their approach to life or is unduly anxious, it becomes difficult for them to cope with day-to-day stress. Consequently, recurring depressions of a reactive nature develop.

Secondary depression refers to depressive episodes that occur as a consequence of some other psychiatric illness such as schizophrenia, phobic states, or alcohol or drug dependence, or as a result of a medical disorder, such as Parkinson's disease or after a viral infection or a stroke.

Bipolar Disorder

Bipolar disorder or manic-depressive illness tends to be a more severe form of mood disorder that affects men and women equally and occurs in about 1% of the population. It consists of periods of elation or mania, alternating with bouts of depression. The depressive episodes last weeks to months and symptoms are indistinguishable from those of unipolar or endogenous depression. The signs and symptoms of elation are the direct opposite to those of depression. The person's thoughts are racing; they are usually overtalkative, restless, overactive and need little sleep. While the word

elation and mania (meaning speeded up), are used interchangeably, elation is not always a pleasant or euphoric state. It can be unpleasant for the individual in that they feel irritable, tense, tired, restless, or angry. This stage is usually referred to as a dysphoric (meaning unpleasant) manic state or a mixed mood. Hypomania refers to a lesser degree of mania. For 50% - 70% of those who have an episode of bipolar disorder, the illness will recur.

Elation or Mania: Signs and Symptoms

- Feeling “high” or “on top of the world”, “better than normal”, or “better than ever before”
- Uncharacteristic irritability or anger
- Great energy and not needing to rest
- Overactive, restless or distractible
- Racing mind that cannot be switched off - “pressure in the head”
- Talking rapidly and jumping from one topic to the other
- Decreased need for sleep
- Excessive and unrealistic belief in one’s abilities
- Poor judgement
- Increased interest in pleasurable pursuits; new ventures, sex, alcohol, street drugs, religion, music or art
- Demanding, pushy, insistent, domineering or provocative behaviour without the person necessarily realising that their behaviour has changed

What causes depression?

While it is convenient to consider the effect of losses and upsets in life, personality, vulnerability, and inherited predisposition to mood disorder as distinct causes, it is often the cumulative effect and the interaction of these different factors that determines whether a person gets clinically depressed.

Studies of depressed people clearly show that losses in life, such as bereavement, physical illness, break up of a relationship, unemployment and financial difficulties, precede depression. It is often where there are several significant setbacks in the months before the depression, when the person seems to have fought back by becoming more determined initially, that the mind eventually succumbs, as it goes through a form of grief or reactive depression. Childhood losses such as the death of a parent, marital breakdown or separation from parents through hospitalisation, predisposes to recurrent depression in adult life. It is also likely that smaller, but personally significant, losses in early life predispose to depression later on. One of the most important antidotes to the losses of everyday life is having somebody in whom to confide. A supportive confidante does seem to limit the traumatising effect of ongoing problems such as financial difficulties, illness, or having a poor relationship with a key relative.

Hereditary factors have been shown, through family, twin and adoption studies, to be of major importance, particularly for the more severe, recurring depressions and bipolar disorder. Surveys of twins have shown that genetic factors contribute some 40% to the causation of depressions of a mild to moderate severity. For recurring unipolar depressions, 50% - 60% of the causative factors are genetic, while for bipolar disorder this figure rises to 70% - 80%. It is important to realise that these are statistical averages based on thousands of case histories and should not be used to determine the genetic vulnerability for an individual.

How a person copes with stress and loss is determined by their personality, which in turn is shaped by a mixture of genetic and early childhood experiences. What may be a mildly upsetting disagreement for one person may be a major catastrophe for somebody who is insecure and has difficulty asserting themselves. It has long been recognised that depression is more common in the winter months and mania and hypomania is more likely to occur during the summer. Unipolar depression occurs more frequently for the first time and recurs in late October or early November and in February or March. Seasonal affective disorder refers to a depression frequently occurring annually in December to February, when the person is tired, oversleeping, overeats, and may have a period of hypomania during the summer months. It would appear that the mood regulating centres in

the brain can have difficulty with the changing meteorological conditions, such as the duration and intensity of daylight, that occur with the change of the seasons. For most, this results in a slight, but barely perceptible shift in mood, but for others it can be an overt, disruptive depression.

The mood regulating areas of the brain which are contained in the limbic system, can be affected by general medical disorders such as under active thyroid gland, viral illnesses, such as influenza or viral hepatitis, Parkinson's disease, or multiple sclerosis, stroke or following the use of mood altering medications, such as steroids and blood pressure lowering medications. Steroids and L-dopa, a treatment used in Parkinson's disease, can induce mania, particularly in those who are predisposed to this condition.

It would appear that where there are significant losses in life or minor losses but with obvious personality vulnerabilities, depression is likely to be of a reactive type. For some it moves beyond this to an endogenous form of depression, where there is broken sleep, early morning wakening, morning worsening of symptoms, and marked slowing of body movements and the thinking process.

When there is a strong family history of depression or bipolar disorder, the person may become depressed without having any very significant upset. Likewise, where this biological vulnerability is quite minor, it will often only result in a mood change when there are major upsetting life events. Generally, it should be possible to understand any individual person's depression in the context of their losses and stresses, life supports and underlying genetic and personality endowment.

Depression in Children

Children, even infants, can be depressed. Surveys show that some 10% of adolescents aged 13-19 have major depressive disorder, while before puberty the rate of depression is less than 2%. It is now generally accepted that children under the age of 12 can develop bipolar disorder.

When depression occurs before the age of 12 it is most often related to difficulties the child is experiencing, such as bullying in school or parental conflict. At that age, depression is more common in boys. After puberty, genetic factors appear to have a greater role in causing mood disorder in

that the most likely predictor of having depression at that age is having at least one parent who has had depression. It is not that upsetting circumstances, such as relationship difficulties, family strife, or peer pressure, are not important, but these events appear to have a more profound and prolonged effect on adolescents who have a family history of depression. This familial inclination has been shown by other researchers to have a largely genetic basis.

Recognising the Symptoms

The signs of depression in children are no different to those of adults (see page 4) but they may not be that obvious, simply because we do not expect a child to be depressed. If a baby gets separated from its mother when she is hospitalised, he may stop eating and lose weight. If the possibility of depression is not considered, the infant may have extensive medical investigations to determine the cause of the weight loss. The second difficulty in recognising depression in young people is that while all of the typical features of depression are present, they are not necessarily expressed in the same way as they are in adults. For example, lack of interest in work or in one's appearance are the typical symptoms for a depressed adult, whereas a child will more often complain of boredom, in other words, a lack of interest in everything. When you enquire about this complaint of boredom, you will usually find that particular aspects of life, such as the football team or pop star they have an interest in, has now become "boring".

Parents may find it difficult to recognise depression in their children because they are reluctant to see it and trivialise it by referring to it as "teenager's moods". While most of the mood changes that teenagers go through are mild and transient and are due to their fight to gain mastery over their life circumstances, it is important to recognise the symptoms of depression if they are present and not dismiss them lightly. This can best be done by going through the checklist of symptoms listed below and if you think that there are some definite symptoms present, you should discuss the matter with your family doctor. There is often a tendency to dismiss depression when it is apparently due to some recent let down, such as not being picked for the football team. A depression such as this may be just as severe, and the upset in life may have only been the precipitating factor, rather than

the main cause of the mood change. For example, a family history of depression may predispose the young person to depression and the upsetting event was simply the final straw that triggered the depression. If depressive symptoms are present, it is important to decide how severe they are and to seek help if they are bothersome.

Depression: Signs and Symptoms

Fatigue:

Uncharacteristically moping about the house, looking tired.

Anxiety:

Worrying excessively about studies, what others think of them, their appearance, or global issues, such as poverty.

Feeling Sad, Depressed or Bored:

A depressed young person may look sad or unhappy, feeling defeated by events at school or in their social life, which they usually took in their stride. They will often complain of a poor relationship with peers or siblings, in that they feel unwanted or inadequate for no justifiable reason. They may complain of boredom, which is a general lack of interest, or have a specific loss of interest in a favourite football team or a particular school subject. Aggressive negative attitude, poor concentration or memory, forgetfulness or losing things, falling school grades. Appearing not to be listening.

Lack of Interest:

Often presents as boredom or lack of interest in their own favourite T.V. programme or pop star, or in their own appearance.

Change of Appetite:

Not feeling hungry, but eating to please or over-eating

Social Withdrawal:

Due to anxiousness, lack of interest, self-consciousness, or feeling depressed. Thinking more slowly, rate of movement and expressiveness is reduced.

Sleep:

Over or under-sleeping, nodding off when watching T.V., in the classroom, or when listening to music, late for school.

Low Self-Esteem:

Feelings of guilt, worthlessness, or inadequacy. Blaming themselves for everything that goes wrong.

Physical symptoms:

Headaches, abdominal or chest pains, frequent visits to the doctor.

Suicidal:

Morbid thoughts or dreams of death or suicide.

Delusions:

Ideas that will not go away, of being inadequate, or “stupid” or “gay”.

Treatment

Depression is an extremely treatable illness with some 80% of people responding to counselling or anti-depressant medication within a matter of weeks. The most common reasons for treatment failure are poor compliance with treatment and incorrect diagnosis.

The different types of mood disorder, namely reactive depression, major depression, recurring unipolar depression, bipolar depression and rapid cycling mood disorder, need individually tailored treatment plans. The plan needs to take account of the losses the person has experienced, their personality and genetic predisposition to depression, the level of family support and complications, such as alcohol abuse, or financial problems they are experiencing. It can be difficult to correctly diagnose the specific type and pattern of mood disorder. It is not unusual for people with recurring episodes of depression to overlook the short lived periods of over talkativeness, trouble getting to sleep at night, irritability or frenetic activity that characterise hypomania. While severe bipolar disorder occurs in 1% of the population in the course of a lifetime, lesser degrees of bipolarity are present in a further 2%. Obtaining accurate information from both the person with the mood disorder and a key family member is essential to ensure that the pattern of the illness is clearly identified and the appropriate

treatment is given. It can take quite a lengthy time before the doctor is clear about how events in a person's life, their personality and any inherited tendency to mood disorder are interacting to cause depression. Alcohol or drug abuse may not be mentioned in consultations with the doctor. When you are part of the management team, these causative factors and mood swing patterns are unlikely to be overlooked, and so the correct treatment approach can be started earlier. It is hard for the person to accept they are depressed, that they need help, and particularly so, if that help is medication. It is even more daunting if the prospect of a recurring mood disorder has to be faced, with the almost inevitable need for ongoing mood stabilising medication. The person needs time and understanding as they adapt to these situations. Getting factual information about their mood disorder is essential. Equally vital is the importance of meeting with others who have come to terms with their illness and the need for treatment. Support group meetings, such as those organised by Aware throughout Ireland, provide an ideal forum to meet others with the same problem. Experiencing the support and understanding of fellow sufferers is invaluable; it frees the person to face the future and helps them realise that there is a life after mood disorder.

Explanation: The symptoms of depression are often bewildering for both the patient and family, and vital that a simple explanation is given of what depression is, why they are feeling so out of sorts, what causes the mood disturbance and how it can be best treated.

Counselling: At its simplest level this is an extension of listening to the person's concerns and that of the family and to familiarise them with the facts on depression. The most important aspect of management of depression is undoubtedly making an emotional link with the person who is depressed. It is essential that this link be established, as the pessimism and negative thinking that is an inherent part of depression will otherwise prevent the person continuing with treatment and following the advice of their doctor. The person who is depressed needs somebody to talk with about how they are feeling. They need to know that they are being heard and understood and they will benefit from firm reassurance that they will recover. Within this confiding relationship, they will also be able to explore losses and hurts and begin to go through

the stages of grieving or start to address the factors that contributed to the depression.

Psychotherapy: This is a more intense form of counselling and, in addition to being a support for the person during the time of distress, it also helps the development of an understanding of their symptoms as a response to current loss in the context of similar early life experiences. A particular form of psychotherapy called cognitive therapy, explores the validity of the negative thoughts that contributes to the feelings of depression and anxiety. By challenging these negative perceptions, alternative ways of looking at situations in life are developed, which in turn generate new solutions. Cognitive therapy is now considered to be an effective form of treatment for depression and it has been shown to be as effective as antidepressant medication. It does appear to have a role in preventing depressive relapses, but many patients find it difficult to apply when they are severely depressed. In these instances, it is best combined with antidepressant medication.

Antidepressant Medication: The most effective treatments for severe depression are antidepressant medications. They usually take at least 2 weeks before they begin to work, and once they have been effective they need to be continued or at least 4 months after the depression has lifted, as the depression is otherwise more likely to recur.

Antidepressants, unlike tranquillisers, are not habit forming. They are not effective where the person has emotional distress or a reactive depression, and should be reserved for people who have definite endogenous features of depression. The older antidepressants introduced in the 1950's and 1960's such as Tryptizol, Anafranil, Surmontil and Prothiaden, are now being replaced by a newer generation of treatments with fewer side effects. The new antidepressants include Cipramil, Faverin, Edronax, Efexor, Lustral, Prozac, Seroxat and Zispin. You will find further details on the different forms of these treatments listed under Suggestions for further reading,

Mood stabilisers: Mood disorders by their very nature tend to be recurring and this is particularly so when the episode of depression is severe or if it is bipolar disorder. For recurring mood swings,

preventative treatments are necessary and these are referred to as mood stabilising agents. Lithium remains the most frequently prescribed drug and is effective as a mood stabiliser in some 70% of cases when given alone or in combination with other agents. Where the mood swings are recurring very frequently, as in rapid cycling mood disorder, other treatments such as carbamazepine, sodium valproate or lamotrigine, are the preferred treatments.

Electro-convulsive Therapy: Electro-convulsive therapy (ECT) is an effective treatment for severe depressive illness, where there are depressive delusions or hallucinations or when other treatments fail. It is usually for depressions with biological or endogenous features, such as broken sleep pattern, early morning waking, weight loss, morning worsening of symptoms, or slowing of mental and physical activity, that ECT is particularly effective.

The optimum treatment for any individual is decided upon after assessing their underlying personality, whether there is a family history of depression or related conditions, whether losses or upsets were experienced prior to the onset of the depression and determining the symptom profile of the mood disorder. While one form of treatment may be effective for a particular type of depression, it is more likely that a combination of antidepressant medication or mood stabilisers and some form of counselling or cognitive therapy will often be more effective.



PART II

Your Role as a Relative or Friend

Depressed people affect others:

Depression and elation are disturbances of emotion and as we are bonded to family and friends by emotion, mood disturbances inevitably affect relationships. For some immediate relatives the impact of an ongoing mood disturbance can be enormous. Surveys have shown that 40% of key relatives of people with depression are themselves sufficiently distressed to need help. It is the ongoing worry, social withdrawal and irritability that most upsets families.

Even if this is not a worry for you right now, it is vital that you understand what happens in relationships during depression, so that you can minimise the disruptive effect it may have on you and your family's lifestyle.

During a bout of depression or elation, the person's perception of what their mood does to them, their family, and friends is often inaccurate. This perception can lead to the person feeling alone, isolated and misunderstood. Inevitably, this will in turn disturb close relationships. It also leads to inaccurate reporting of the extent of their mood disturbance and its consequences to the doctor. It is essential that a close friend or relative work jointly with the person with the mood disorder and the doctor or therapist as part of the management team. This three stranded team approach ensures that the necessary care and support is in place to reduce the person's sense of isolation, that the doctor gets to know the full extent of the mood disturbance and that any adverse effect of the illness is addressed early, and better still, prevented. Concerned family members or friends usually want to help and they have a particularly important part to play in aiding recovery and limiting the damaging effect of mood disturbance. Not infrequently, the person who is ill may feel they are an additional burden on their families in expecting them to help and be supportive in this way, or they may see it as relatives are usually of enormous assistance, provided

that they understand the facts about the mood disorder, have the ability to listen and can accept what the person is experiencing, without feeling they are responsible for relieving this distress.

Family members often find it hard to understand why people when depressed get to work, hold down jobs, and even socialise, yet at home they are irritable and withdrawn. What is even more perplexing is that they can snap out of depression when visitors call to the house. This is a well-recognised aspect of depression of a mild to moderate, or even a severe, degree. Not infrequently when someone is admitted to hospital with a severe depression they can appear to be perfectly well for the first few hours or days, but then the true picture of depression emerges. In other words, they can reflexively and unconsciously put on a bright face when they go to the doctor or socialise, but cannot sustain it. The mask shown to the world, other than close family, is barely affected in the early stages of depression.

A further significant reason for involving a key relative, particularly a spouse, is that there may be a poor marital relationship either preventing full recovery or contributing to, or being the main cause of, the depression. Research has shown that where the well spouse is critical of the person with depression that a depressive relapse can be reliably predicted. In such instances, the impact of marital difficulties on the person may not be obvious to the doctor or therapist, as neither patient nor relative reports what is happening in their relationship, believing it to be irrelevant or that they are simply reluctant to address the matter as they see no ready solution. In addition, very often ongoing problems such as marital difficulties, financial problems or unresolved, prolonged grieving become so much part of the person's life that they cannot necessarily see the effect it is having on their mood.

Finally, the constant train of altered perception, overly pessimistic in depression and unduly optimistic in elation, can have devastating consequences. In a depression a person feels isolated, unwanted, guilt-ridden, and useless, resulting in avoidance of family and friends, irritability, hostility, impulsive resignation from work, making reparation for imagined wrong doings and even suicide. In elation the exhilaration, enthusiasm, and confident grandiose behaviour tends to result in overbearing,

demanding and insistent, even aggressive behaviour, which if unchecked, results in over spending, extra marital affairs, promiscuity, and engaging in business and other schemes, that are so ill judged, that they are bound to fail. A relative or friend is an essential ally when the person's thinking is not as it should be. Enlisting the support of such an ally is invaluable in detecting a relapse of depression or elation at an early stage, and so being able to counter the excessively pessimistic or optimistic thinking that leads to so many difficulties. Early detection of a mood change prevents the person's life from being scarred by the complications of mood disorder. When this prevention programme is employed effectively, it means that once a person's mood subsides they can continue with their lives, rather than having to untangle problems in so many different areas of their lives.

Why the divide?

Depression changes the way the person both feels and perceives themselves and the world about them. In addition to a negative perception of themselves, the person often has blunted feelings that give a sense of being shut off from the world, as if they were behind a glass wall. To counter this detached feeling, they will either cling to the person from whom they feel shut off or accuse them of being less affectionate. What the person doesn't realise is that it is their own feelings that are blunted. All too often, this leads to marital friction. Complaining about their spouse is frequently the first symptom of depression. While the misperception will impact on any major relationship that the person has, it can also affect other facets of a person's life: a teenager may become excessively preoccupied about their appearance, fear of having cancer or AIDS may predominate another's thinking, and, for some, needless concern about money or taxation can be crippling. It is all too easy for family members or friends to become embroiled in a tangle of debate with the person who is depressed, without realising that the issues being discussed are based on the depressed mind's misperceptions. Emotional withdrawal, clinging, irritability, and incessant worry about issues that have no basis in reality do take their toll on relationships. In depression, the focus of the mind may differ from person to person, but it is often the same issues that become a recurring concern when an individual has a depressive relapse.

Mania or elation can have an even greater and more obvious detrimental effect on relationships. In the high phase, the person is emotionally expansive, in contrast to the contracted state of depression. It is as if the person breaks the usual boundaries and in doing so disrupts the previously close, intimate relationships with immediate family and friends. More distant friends or work mates will not usually, at least initially, notice the change. The person becomes more attracted by the heightened sense of feeling of new situations and the ability to carefully weigh up situations is dominated by an overly positive attitude. What happens to judgement in elation is best understood by thinking of how we usually make a decision, such as buying a new coat. We ask ourselves do we need it, is it good value, will it wear well, will it match other colours and so on. The elated mind can only see the positive side and the counter balance negative side, such as that it is too expensive or that they purchased a new coat recently, is not considered. The reverse happens in depression, so that the coat is not purchased. The constant attractions that this heightened sense of awareness and overly positive view leads the person to stray from their commitments, values, and relationships. This inevitably places an enormous strain on previous stable and satisfactory relationships, without the person, and sometimes the immediate family, realising that they are in an ill, manic state. Alcohol, street drugs, teenage behaviour, personality of being easily “led astray” are often the reasons cited mistakenly by relatives for the person’s changed behaviour.

When depression or elation is not seen as an illness and when the person is blamed for their behaviour, it leads to a breakdown in communication, with marital disruption or alienation from the family. Even when the changed thinking, feeling and behaviour are seen by relatives as illness, the person will often have insufficient understanding and insight, and so may refuse to get help, shun the family and behave in a reckless manner or attempt suicide.

Changes in feeling and judgement of mood disorder will affect every close relationship, but to what degree, will depend on the severity of the illness, the promptness with which help is sought and the readiness to enlist the help of a close relative or friend.

How families react to mood disorder

When a family first learns that one of its members is ill with depression or elation, after getting over the initial shock, they will search for a solution. Usually this entails encouraging the person to get professional help. They will be supportive and show concern, want to know what the diagnosis is, what treatment has been recommended and when the person can expect to recover.

This caring, supportive approach will continue if the person recovers on schedule and remains well. However, if recovery is slow or there are several remissions and relapses, then care gives way to frustration. Subtle manifestations of this impatience with lack of progress are making suggestions to the person that they should exercise, diet or get a second opinion. The more forthright family members may have a “no nonsense” approach and will bluntly exhort the person to “pull up their socks” or “snap out of it”.

If, as time passes, these different forms of interventions by family and friends are proving ineffective, they begin to despair. This is evident in that a relative may no longer be making well-meaning suggestions, there is a tendency to enquire less often how the person is feeling, and the family member may begin to become detached emotionally from the illness. More blunt speaking relatives or friends may frankly say they do not want to hear about the symptoms.

When someone we care for becomes ill we react as we do to any loss. Mood disorder is a temporary loss of the person we once knew. As with any loss we go through stages of shock or disbelief, searching for what is lost by showing care and concern, this is followed by anger or agitation, if the searching is unsuccessful. Despair or sadness and ultimately acceptance of the situation then follow. While the person who is ill may feel hurt by these reactions, it is important to realise that it is a normal and understandable reaction to loss, that if the situations were reversed they would react in a similar manner and that they should endeavour not to take it personally. Both the person who is ill and relatives and friends need to understand how each reacts in these situations and how with a factual understanding of both mood disorders and one’s reactions to it, they can keep the relationship at

a caring, supportive level until recovery is achieved. It is this well informed, caring and supportive approach that relatives can bring to the management team, and, so speed recovery and, equally importantly, prevent marital and family breakdown, unemployment, alcohol abuse, financial difficulties and even suicide.

Depressed Parent: Effect on Children

Children are just as much affected by depression or elation as adults, if not even more so. They are particularly vulnerable to the negative impact of mood changes, as they are less able to take a detached view of what is happening and separate the mood-based behaviour from the person. Although the child may know that there is something amiss at home, when they see a parent unable to go to work, or being admitted to hospital, they are all too frequently given little or no explanation and have to figure it out for themselves. Once a child is given a factual explanation about the parent's depression or elation, in terms appropriate to their level of understanding, told what treatment is being prescribed and what the likely outcome is, they become less frightened. In the absence of this information, they will usually imagine that something more sinister is happening, such as their parent being terminally ill. A depressed parent may be withdrawn, negative in their outlook, or extremely critical, and all of this impacts on the children. It is usually difficult for the well parent to stand back and separate the depression-related behaviour and not to react as if the ill parent had full control over matters. It is even more difficult for children; they can quickly absorb the depressed parent's view of the world and of themselves. If in a depressed state, a parent is constantly finding fault with a child it will often result in the child having a similar negative self-image.

Children respond to a parent's mood changes in a similar manner to adults by going through stages of initially being caring and supportive. They will nearly always take the lead from the well parent. If the well parent is supportive and understanding and has a positive attitude to the management of the mood problem, so too will children. Like adults, children will tend to cope with continuing illness or frequent relapses by becoming angry or depressed.

It is not unusual for the well parent to rely on the eldest child when their partner is unwell. While this may help both child and parent initially, it can result in adult type responsibilities being placed on the child, making them an adult before their time. It can have a detrimental effect on the parent's relationship with each other, because as the depressed parent recovers they will often find that their position and role in the family, which has been taken over by the eldest child, is slow to be returned to them. So while openness about depression or elation is necessary to reduce the tendency of children to worry, it is important that they are not overburdened and that they are encouraged to enable the recovering parent to resume their role in the family once again.

Advice for Relatives and Friends

1. A mood disorder is an illness and it can impact enormously on the lives of family and friends. Inevitably your initial reaction will be a spontaneous one of shock, disbelief or anger. It is easy to get entangled in the emotional web that grows out of these emotional reactions. Remember that depression and bipolar disorder are illnesses; they have signs and symptoms and can be effectively treated. You must see it as an illness and not blame the person for their behaviour. This is not always easy to do, but the more you can do so, the more success you will have in maintaining your relationship and helping steer the person to recovery.
2. You are bonded to the person who is ill, so whatever affects them will impact on you emotionally. Consequently, and as you can do much to limit the negative impact of the mood disturbance, both on your own health and that of the person you care for, it is vital that you are available to help out on the management team.
3. Support the person unconditionally as they are ill. When you become familiar with the facts about mood disorder and its emotional impact, you will be best placed to deal with it.
4. Get as much information about depression and bipolar disorder as you can. Knowledge is power and the better understanding you have of the condition, the more you will feel in control of the

situation. Lectures, audio and audio-visual tapes, and books are readily available on many different aspects of depression. In addition to learning the signs and symptoms and other facts about mood disorders, it is equally important to know how it makes you feel and react.

5. The most efficient way to treat a mood disorder is to have a three member management team, consisting of the person who is ill, one or several family members or a close friend and the treating doctor or therapist. This team should operate on a partnership basis, as each has an equally important role. Whether it is accurately assessing mood, reporting on progress between visits, providing ongoing support or preventing suicide, the team works best when the members genuinely listen to what each other is saying and value their respective points of view, as would any good partner.
6. It is not your fault that the person is depressed or has a mood disorder. Even if your relationship with the person is problematic, you did not choose that the person developed this illness, no more than they did. Sometimes you may blame yourself or be blamed, but anger, blame and guilt are usual reactions to illness. So do not feel guilty. If you are being blamed, do not take it personally, as it is the illness talking. Time and time again you will have to be objective and separate the person from the particular mood they are in and its effect on them.
7. Be aware of the emotional interactions that occur in mood disorder. When you feel upset by remarks or behaviour, endeavour not to react with anger. Stop and analyse the situation and remember you are dealing with illness. The more objective you can be, the less entangled the situation will become.

Support group meetings for family members and friends are an ideal venue to both learn about the effects of the illness and to experience how you can deal with hurt feelings. It is not unusual for family members or friends to feel isolated and bewildered by the illness and their response to it. Meeting others who have had the same experiences and seeing how they cope with them effectively can be a

real eye opener. Knowing the facts is not sufficient, so do avail of the opportunity to join a support group and learn at first hand how you can best deal with your feelings.

Just as you need a factual and emotional understanding of mood disorder, so does the person who is ill. Again, coming to terms with and understanding mood disorder is difficult for those who suffer from it. Support group meetings also provide an invaluable forum for people with the illness to meet others with the same difficulties. In fact, those who have managed to avail of the enormous wealth of information, care and support that is available at these meetings are uplifted and quickly become equipped with the most efficient management strategies. It is vital that you encourage the person to attend these support groups, as they themselves, when ill, will find it hard to imagine the change that they can bring about.

8. Do not bottle up your feelings, as they will only lead to subdued hostility and a superficial and detached relationship. If you are upset by an event or a remark, it is best to first decide whether this was mood related, and if so, to ensure, as part of the partnership team, that this mood change is being tackled. It is also important to express your hurt at the appropriate time, but not in an accusatory manner. You should say how you feel, such as “I was hurt by what you said to me yesterday”, rather than retaliating by making hurtful remarks and dredging up similar episodes from the past. What you should endeavour to do is to help the person to limit their upsetting behaviour and to get them to accept responsibility for it, without blaming them. This type of intervention is usually successful in limiting the negative impact of depression. The person’s mood may not always allow this type of intervention to occur immediately. It is, however, vital that once the acute phase of illness has passed that you talk over the upsetting events, otherwise such situations are likely to recur, and eventually will have a progressively damaging effect on your relationship. Initially, it may be best to explore these difficulties in a joint meeting with the doctor. Also, support group meetings can be particularly effective in helping you decide how best to approach these delicate issues. It is also recommended that

the person who is ill be encouraged to facilitate this form of non-judgemental exchange of feelings, as it helps them sustain the relationship and does enable them to take responsibility for their behaviour, which in turn limits the likelihood of it recurring.

9. Almost all immediate relatives or close friends of an individual with a mood disorder will, as has already been mentioned, be emotionally affected. So do acknowledge your needs and get appropriate help. Your first response should be to endeavour to keep up your routine of work, leisure and social outlets. Being well informed about the facts of mood disorder, learning how to address conflicts that are still arising and how to express your feelings about the illness through regular attendance at support group meetings and finally being part of the management team are the most significant steps in addressing the emotional implications of the illness.

Others are affected at a deeper level and may need to see a doctor or therapist, alone or jointly, on a number of occasions. Obtaining help for yourself is a sign of strength, not of weakness. Feelings are hidden out of fear and fear should be confronted.

10. Becoming part of the management team is one of the most significant contributors to recovery. If this team is functioning effectively, it will limit the duration of mood swings, reduce or prevent hospitalisations, reduce days missed from work and help limit the complications associated with mood disorder. It is essential that the person who is ill is well informed of the need to have a key relative or friend involved in management. Aware recommends that the person with the illness should choose a key individual, preferably their next of kin or at least somebody whom they are in regular contact, to join the management team. The person chosen must be somebody in whom they have confidence, whose judgement they trust and who is familiar with the factual and emotional aspects of the illness.

If there is a depressive relapse, the person who is ill is usually the first to realise that they are not well, but they may need prompting from a relative to seek help. However, in elation it is a family member who will usually first notice the upswing in mood, and, as

such, they have a major role in spotting symptoms of mania. How this should be done, what particular symptoms should be watched for and how the observations should be communicated to the person, should be decided upon with the patient when their mood is stable. When elated the person may show varying degrees of resistance to this approach, but they will usually be thankful later for your timely intervention when they realise it prevented an admission to hospital or a reckless spending spree. The person with the illness will often need time to adjust to this form of intervention. For those with severe recurring mood disorder it is essential and often life saving. This often means that the person has to choose to trust you to help spot and prevent a significant relapse or else rely on their own ability to deal with an illness that can alter their judgement.

11. If the mood is disabling for more than a short period of time, you or some other family member may have to take over some of the person's role in the family. This may range from doing the shopping for food or earning additional money. By agreement, you may have restricted access to money or to driving the car or be supervising medication. Whereas these interventions are useful at the time, there is an understandable tendency to be reluctant to hand back control to the person when their mood settles, particularly where there has been a prolonged mood change or frequent relapses. It is important to return these controls as soon as possible, as many find it hard to cope when separated from their usual lifestyle. This calls for flexibility which hopefully will in turn result in a readiness to reinstate these controls, should it become necessary in the future.
12. An immediate relative can feel shut off from the depressed person's life because of illness and even more so when they are confiding their feelings to a doctor or therapist. This exclusion may cause resentment and a tendency to belittle the importance of the doctor-patient relationship. Having a relative actively involved in the management team prevents this sense of isolation.

The patient, on the other hand, may feel their privacy is being intruded upon when a relative is also seeing the doctor. It is quite

feasible for you as a relative or friend to monitor the person's mood, support them and report on progress without intruding on the personal issues about which they need to talk confidentially to the doctor. Monitoring of mood and its management can be separated from the counselling or psychotherapeutic aspect of the treatment plan.

13. Both you and the person you care for should feel you can speak openly to the doctor about your concerns and know that these are being addressed. The person who has the mood disorder should feel cared for, have confidence in the treatment plan and you should, if requested, be able to get a second opinion.
14. When you visit the doctor, it is a good idea to have documented the person's mood on a daily basis in the form of a graph (see page 31). This is a valuable form of feedback for the doctor, especially when it is matched with one graphed independently by the person with the illness.

It is also useful to make a brief note of any concerns you have about the illness and its treatments to list these, so that you derive most benefit from the consultation.

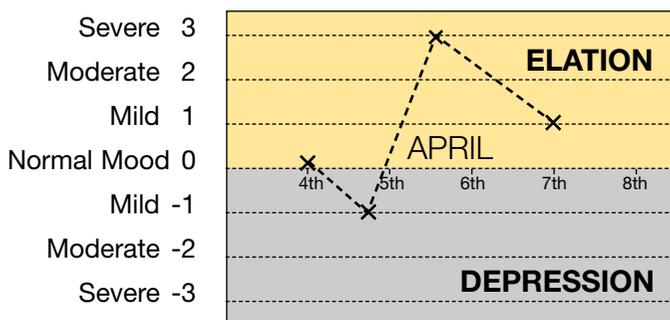
15. Additional joint or family therapy may be necessary where there are marital difficulties, unresolved issues relating to emotional consequences of the illness or where there are conflicts regarding monitoring of mood.
16. Quite frequently the person who is depressed refuses to get help, as they see it as a sign of failure, that it will not work, that it will alter their relationship with you because they are in an angry frame of mind and see seeking help, as giving into you. Men in particular have a need to feel self-sufficient, they find it difficult to talk and tend to drink as a way of coping. You may consider this refusal to get help as a rejection, but do not take it personally. Pushing people away is a feature of depression. Identify whether it is having a diagnosis of depression, needing treatment or some other aspect that bothers them specifically. Talk about what you are feeling and the effect the illness is having on you. Present them with the problem

of depression as something you would tackle jointly. For example if the person's sleep disturbance keeps you awake at night, it is then a joint problem and can be presented as such to the person who may be willing to address it by talking with the doctor. They may be prepared to take the advice of somebody they know who has been treated for depression. It is useful to give literature about depression and be gently persistent in your approach. To highlight the level of your concern about the problem, it is useful to make an appointment to discuss the issue with them. Don't be afraid to ask them to get help just to please you. If you consider that there is a risk of suicide or other behaviour that is likely to have a detrimental effect on the person with the illness or others, you have a responsibility to get that person help, as their judgement is impaired at that time. In some extreme instances this may mean that person has to be hospitalised involuntarily and this is something that you should discuss with your doctor. By applying the recommendations in this booklet, it is usually possible to reduce the need for admission to hospital, but when these recommendations are proving ineffective, because of the severity of the situation, it is important that you remain objective and remember that you are dealing with an illness.

17. Do not avoid bringing up the subject of suicide. If you sense the person's hopelessness and despair, it is important to get them to talk about it. People often fear this will increase the risk of the person harming himself or herself. Most who are depressed will have thoughts in varying degrees about suicide, and having discussed it with you, it is often an enormous relief to them. What matters is how extensive are the suicidal thoughts. Has the person any intention of harming himself or herself, have they made a plan and do they have any hope. It is those who feel increasing hopelessness, that they are a burden on others or are unwanted, and cannot see an alternative, that are at serious suicide risk. It is essential that you get the person help and convey your views to the doctor or therapist.
18. Remember that depression and bipolar disorder are illnesses that can be effectively treated. You have an important role to play in

ensuring that the person who is ill receives treatment, that they are supported and cared for until they recover and that the complications so commonly associated with mood disorders are prevented. It can be a difficult time in your life, but by following the guidelines set out in this booklet and providing unconditional support, you will be well placed to help the person recover and limit the disruptive effect of the illness on both of your lives.

Mood Graph



Figure

A daily graph of mood made, separately and without comparing ratings, by the patient and relative is an invaluable record of mood, as it is often difficult otherwise to accurately report mood changes between consultations. Both of you should make your separate records of the patient's mood by making an 'x' on the graph just before going to sleep at night. If you consider that the mood on the 4th April in the graph normal line at the 4th. On the 5th, if you consider the person was mildly depressed you make your mark 'x' across from -1 and down from the 5th.

A severe elation, that is an elation as bad as the person has ever experienced, is rated for the 6th of the month. The grades of mood changes are determined by what you both regard as mild, moderate and severe for the patient, so in this way it becomes an accurate reflection of the person's mood. It is best to keep these records in separate copybooks, such as an ordinary A5 copy as you then have a safe record that you will not easily lose. You should bring these records with you each time you visit your doctor.

Glossary of Terms

Biological Depression: This refers to depression with symptoms and signs such as weight loss, wakening repeatedly during the night or early in the morning, feeling worse in the morning, slowing of thinking and body movements and guilt feeling. This depression is called biological as the disruption it causes are to the biological functions of sleep, appetite, weight, and sex drive. Furthermore, it has been observed that depressions of this type tend to run in families or are known to be inherited. Therefore, they have a biological or chemical basis, rather than being primarily determined by environmental events. The term “biological” is often used interchangeably with “endogenous” - that is depression coming from within.

Bipolar Disorder: This is now the term used for manic depressive illness. It refers to the two “bi” poles or aspects of the illness, namely mania and depression.

Bipolar I (BPI) Disorder: Where the more severe form of elation, namely mania, is present. This is defined as the presence of features of mania for at least one week and which is causing disruption. There may also be varying degrees of depression or the mania may be the only aspect of this form of mood disorder.

Bipolar II (BPII) Disorder: Where there is major depressive disorder and hypomania, which is the lesser degree of mania, lasting from 4-7 days, but is not severe enough to cause marked impairment in social or occupational functioning or to require hospitalisation.

Clinical Depression: Refers to the more prolonged and intense experience of depression than is encountered in normal depression, with which the person is having difficulty coping. “Clinical” means that it needs clinical or professional attention.

Cognitive Therapy: A type of talking therapy in which the person’s depression or anxiety is considered to arise from faulty negative thinking. The therapy helps question the validity of the thinking, enables the development of more positive views, which in turn generates new solutions.

Delusions: False ideas that a person firmly believes in and cannot be changed by rational argument. In depression the delusions may be that the person has carried out some crime or they have cancer, when there is absolutely no evidence to support this. In mania, the delusions are usually grandiose in that they may believe that they are god-like or have miraculous healing or other extraordinary powers.

Depression: Both a symptom, when it refers to a dispirited feeling, and a condition or a diagnostic entity in which there is a reduction in mood, dulled thinking, sapped energy and loss of interest in work, food, sex and general every day activities and disrupted sleep.

DSM-IV: The Diagnostic and Statistical Manual - IV Edition (DSM-IV) is an agreed method of defining and classifying psychiatric disorders prepared by the American Psychiatric Association.

Dysphoric Mania or Mixed Episode: Refers to a mixture of manic and depressive symptoms occurring simultaneously, so that rather than feeling elated the person feels irritable, angry or depressed. It is probably best to consider it as a variant of mania, as it is usually obvious that the person is overactive, restless, overtalkative and requires little sleep and responds best to the treatment used for the elated form of the mania, rather than anti-depressant medication.

Dysthymia: A form of low-grade depression, more intense than normal depression, but less than major depressive disorder, that lasts for at least 2 years. It usually starts in the late teens or childhood and may go on to develop into episodes of major depressive disorder.

Elation: This term is often used interchangeably with the word “mania”; it is a general term to describe a happy or pleasant mania where the person feels euphoric, in contrast to the unpleasant dysphoric mood and is usually accompanied by overactivity, overtalkativeness, restlessness, reduced need for sleep and a sense of brimming over with energy and ideas.

Electro Convulsive Therapy (ECT): The application of an electrical charge to the anaesthetised patient’s head for a brief period to produce a minor seizure or fit. The latter is generally well controlled and barely perceptible, as muscle blocking agents are given with the anaesthesia. ECT is extremely effective in treating severe depression with biological features or for

depressive delusions that are resistant to anti-depressant medication and other treatment. It is occasionally used for mania that is failing to respond to medication.

Endogeneous Depression: “Endogeneous” means generated within, to distinguish it from external or reactive depression. The term is used interchangeably with “biological” depression and its main features are a broken sleep pattern, early morning wakening, weight loss, feeling worse in the morning, guilt, slowing of thinking and body movements and an inability to be cheered by pleasant events.

Hallucination: A sensory experience of sound, vision, touch, smell or taste for which there is no objective stimulus or explanation. Most commonly it is experienced as hearing a noise or voices in the head, which the person perceives as not being their own thoughts. In depression it may be a voice telling the person that they are bad or evil, blaming them for wrong doings or telling them to harm themselves. In mania it may be a voice or vision or what the person perceives as God or a supernatural power or where they are being instructed to carry out a particular mission.

Hereditary or Genetic Factors: We inherit genes or genetic factors from our parents as coded chemical messages in the ovum and sperm. When these messages from our respective parents come together they instruct body cells to make certain chemicals, which determine our height, weight, hair colouring and other features. They also provide the chemical factors that determine the range of mood experience we are able to have.

Hormones: Chemical messengers produced by glands in the body. The ovary makes the sex hormones, oestrogen and progesterone, the testes generate testosterone and the adrenal gland produces adrenalin and steroids. These hormones are released from the glands into the blood stream and are carried to different areas of the body where they regulate the function of the brain, the gut, the heart and so on.

Hypomania: This is a lesser degree of mania, where the person is persistently elated or irritable for at least 4 days and has at least 3 other symptoms, is not causing major impairment of functioning or likely to require hospitalisation.

Limbic System: This loosely refers to areas of the brain, such as the

thalamus, hypothalamus, hippocampus and the temporal and frontal lobes and their interconnections. It is these complex interconnecting systems, much like a railway system linking train stations, that is involved in determining and regulating our emotions.

Lithium: This is a natural element which is quite like sodium and is found in soil. It has been shown to be effective in treating mood swings of recurring depression and bipolar disorder. It is also used in combination with anti-depressant medication to treat depression that is failing to respond to anti-depressant medication alone. The dosage of this treatment needs to be regulated carefully, as it is easy to be on too little and not receive its benefit, or be on too much and have toxic side effects. For this reason, it is necessary to do blood tests to measure the body's concentration of Lithium when on this treatment.

Major Depressive Disorder: This is defined as the presence of 5 or more of the 9 common symptoms of depression for longer than 2 weeks. In addition, the symptoms are causing significant distress and are interfering with the person's ability to fully function.

Mania: This is a speeded up, expansive state in which the person is overactive, overtalkative, restless, elated or irritable, grandiose, needs little sleep and is excessively pursuing pleasurable activities. To meet the usual criteria for mania, 4 or more of these symptoms need to be present for at least 1 week and to be causing marked disruption in someone's occupation, social activities or relationships with others.

Manic Depression: Refers to depression of bipolar disorder or manic depressive illness where there is alternating episodes of depression and mania. As a term, manic depression or manic depressive illness has been replaced by "bipolar disorder".

Mood Disorder: A disorder of feeling that is either depressed, as in depression or elevated as in mania.

Normal Depressions: Mild and short lived shifts in mood, often referred to as the ups and downs of every day life, or the Monday morning blues. Normal depressions, by definition, are within our coping abilities and normally occur following some unexpected negative event.

Personality Based or Neurotic Depression: This is a recurring, reactive depression occurring following what are quite often trivial upsets, but have a significantly distressing effect because of the person's underlying personality. If a person has substantial anxiousness, perfectionism, rigidity, sensitiveness or unassertiveness they will have difficulty coping with minor negative events on a recurring basis.

Rapid Cycling Mood Disorders: Defined as being 4 or more episodes of mood disturbance, either major depressive episode, or hypomania, in the previous 12 months. It came to attention as an entity in its own right, as it was noted to be particularly resistant to treatment with Lithium.

Reactive Depression: This depression is directly related to a loss or negative life event. The person feels distressed, anxious, sad, angry, or irritable, is often worse in the evening, tends to comfort eat and gain weight rather than have a poor appetite, may have trouble getting to sleep and can still be cheered by pleasant events.

Seasonal Affective Disorder (SAD): Slight shifts in mood with the seasons are quite normal, but where they are more prolonged and intense, they are called seasonal affective disorder (affect meaning emotion). Depressions are more common in the Winter and mania is more likely to occur in Summer. The brain biochemistry of those who get a seasonal affective disorder seems to be more affected than usual by atmospheric changes.

Thyroid Gland: A small gland in the neck, just below the Adam's apple and you usually cannot feel it unless it is enlarged. It produces thyroid hormones, which circulate around the body and help regulate body and brain metabolism and mood. If too little (hypothyroid) or too much (hyperthyroid) hormone is produced, it will affect mood.

Suggestions for further reading

- Audiotape: **Helping You Defeat Depression**, Dublin, Aware, 1994.
- Blackburn, I.M., **Coping With Depression**, Edinburgh, Chambers 1987.
- Brown, G.W., and Harris, T., **Social Origins of Depression** London, Tavistock Publications, 1979.
- Burns, D.D., Feeling Good. **The New Mood Therapy** New York, William Morrow 1980.
- Corry, M., **Postnatal Depression - A guide for Mothers and Families**, Dublin, Aware, 1991.
- Duke, P, and Hochman, G., **A Brilliant Madness - Living With Manic Depressive Illness**, New York, Britain Books, 1992.
- Graham, P. and Hughes, C., **So Young, So Sad, So Listen**, London, Royal College of Psyschiatrists, 1995.
- Greist, J.H., and Jefferson, J.W., **Depression and its Treatment**, Warner Books, 1984.
- Milligan, S., and Clare A., **Depression and How to Survive it**, London, Ebury, 1993.
- McKeon, P., **Coping with Depression and Elation**, (Revised ed), London, Sheldon Press, 1995.
- McKeon, P., **Bipolar Disorder - A Guide**, (Revised ed), London, Sheldon Press, 1995.
- McKeon, P., **Depression: The Facts**, Dublin, Aware, 2000.
- Rush, A.J., **Beating Depression**, London, Century, 1983.
- Shamoo, T.K., and Patros, P.G., **Helping your Child Cope with Depression and Suicidal Thoughts**, San Francisco, Jossey Bass, 1997.
- Styron, W., **Darkness Visible**, London, Jonathan Cape, 1991.
- Weissman, N.M., and Paykel, E., **The Depressed Woman - A Study of Social Relationships**, Chicago, University of Chicago Press, 1974.
- Winokur, G., **Depression - The Facts**, Oxford, Oxford University Press, 1974.
- Wolpert, L., **Malignant Sadness: The Anatomy of Depression**, London, Faber and faber, 1999.





Objectives

- Help patients with depression and elation, and their families, cope with the illness and benefit from the standard treatments by providing both factual information about the disorders and supportive group therapy sessions.
- Foster an increased public awareness of the nature, extent and consequence of mood disorders.
- Promote research into the causes and the effective treatment of mood-swings.

Aware Services

Support Group Meetings

Are available at some 60 locations throughout the Republic and Northern Ireland for people with depression and their families. Here people can get the information and emotional support they need, learn skills to overcome depression and build self-esteem and prevent relapses. Research shows that support groups are effective.

Helpline Counselling Service

Aware run a Helpline Counselling Service from 10.00am to 10.00pm (Monday to Wednesday) and from 10.00am to 1.00am (Thursday to Sunday) at **1890 303 302**. It provides a listening ear for people in distress and helps people with depression and their families explore solutions to their difficulties.

Information

Aware hosts public lectures regularly, provides literature and audio tapes on depression, postnatal depression, depression in the workplace, bipolar disorder, lithium and carbamazepine therapy and a guide for relatives of people with depression. We distribute free depression information packs to those who write to or phone Aware.

Mail Order Book Service

This service brings over 30 books on depression and other psychological difficulties to those who do not have ready access to a well-stocked book shop. A mail order book catalogue is available from our administration office.

Beat the Blues

Aware presents an educational programme, Beat the Blues, to senior-cycle students in second-level schools. It has proven to be a highly effective way of increasing awareness and understanding of depression and helping young people become more open about emotional difficulties. Aware is happy to bring this service to schools in your community.

Aware Magazine

This informative magazine is published and regularly features articles on depression and related topics. It is available by subscription from the Aware office and on the website **www.aware.ie**.

Charity Shop

It is located at 147 Phibsborough Road, Dublin 7 and stocks a wide range of clothing, books and household items. Our mail order books can be purchased directly from the shop.

Research

Aware funds the only ongoing Depression Research Unit in Ireland and our researchers are currently engaged in studies of the genetics of the depressive and bipolar illness. They have studied public attitudes to depression, the management of depression in general practice, and the effectiveness of support group meetings.

Website

At **www.aware.ie** you will find up-to-date details on lectures, support groups, fundraising events and our publications.

A Voice in Europe and Beyond

Aware is actively engaged with a number of advocacy organisations throughout Europe and North America. In particular, it is an active member of Gamian which is campaigning to improve the availability and quality of care provided for people with psychiatric illnesses.

Contact Details:

Aware

72 Lower Leeson Street,
Dublin 2

Tel: 01-661 7211

Fax: 01-661 7217

Helpline: 1890 303 302

Email: info@aware.ie

Website: www.aware.ie

Aware Defeat Depression

Phillip House, 123-137 York Street
Belfast, BT15 1AB

Tel: 048 903 21734

Fax: 048 903 21735

Helpline: 084 5120 2961

Email: info@aware-ni.org

Website: www.aware-ni.org.uk



Aware Helpline
LO-CALL NUMBER

1890 303 302



Aware

Helping to Defeat Depression