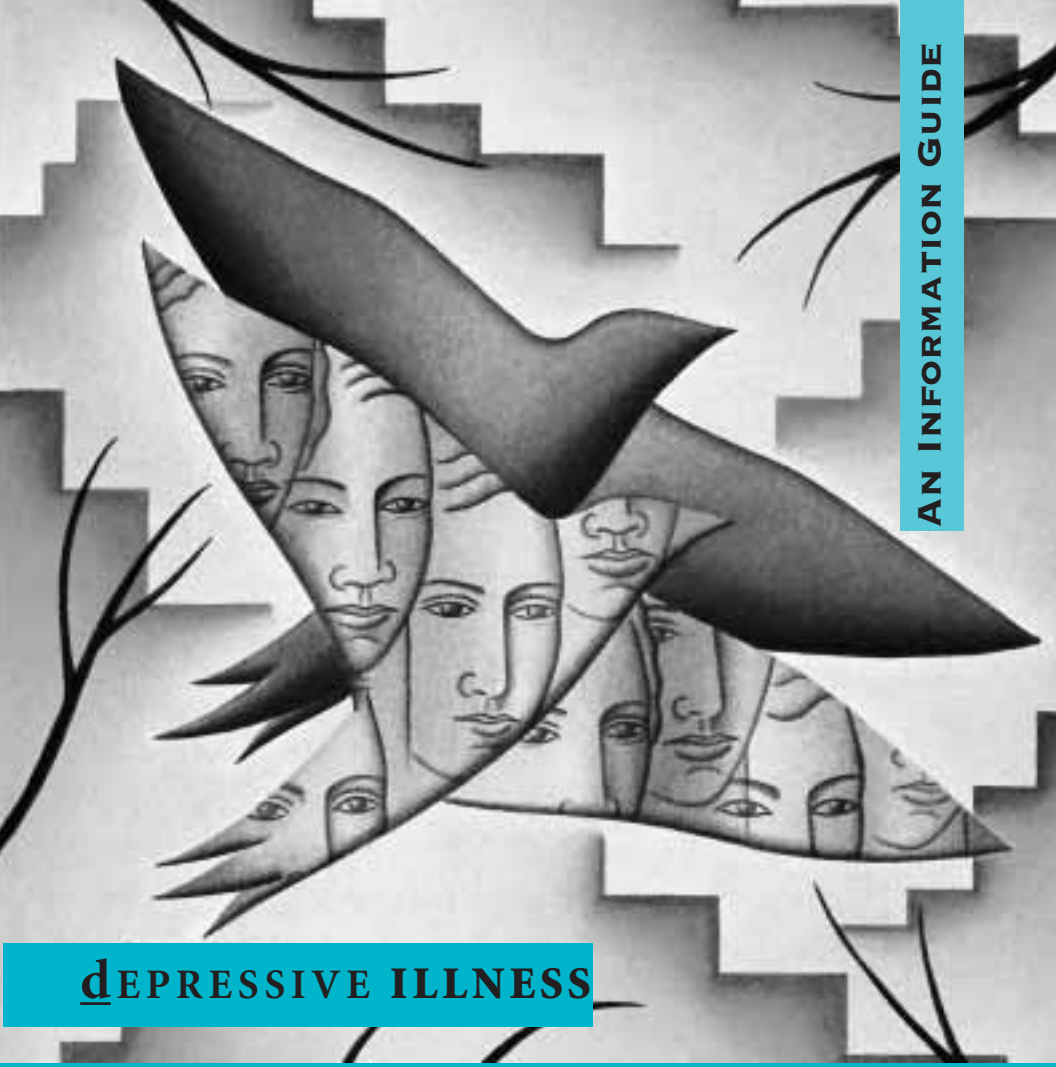

An Information Guide

Depressive Illness

Christina Bartha, MSW, CSW
Carol Parker, MSW, CSW
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camh
Centre for Addiction and Mental Health
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INTRODUCTION

This guide is written for people living with depression, their families and anyone interested in gaining a basic understanding about this illness, its treatment and management. It is not a substitute for treatment from a physician or mental health professional, but it can be used as a basis for questions and discussion about depression. This handbook covers many aspects of depression and frequently asked questions. With respect to drug treatments, new medications are frequently being developed and may not have been available at the time of publication of this guide.

1 UNDERSTANDING DEPRESSION

> *"Depression is such cruel punishment. There are no fevers, no rashes, no blood tests to send people scurrying with concern. Just the slow erosion of the self, as insidious as any cancer. And, like cancer, it is essentially a solitary experience. A room in hell with only your name on the door. I realize that every person, at some point, takes up residence in one or other of these rooms. But the realization offers no great comfort now."*
>
> — Martha Manning *Undercurrents* (1994)
> author/therapist who has dealt with major depression

The pain and isolation of depression, a psychiatric illness, is difficult for many people to understand. Depression is a word that is used both for a sad, despairing mood and for a psychiatric disorder. Everyone feels sad, down or blue at times, often following a disappointment, loss of a loved one or other traumatic life event. This is a normal reaction and our depressed moods usually lift fairly quickly. For 10 to 15 per cent of men, and 15 to 25 per cent of women, a depressed mood can persist and become a more significant mental health problem, commonly referred to as clinical or major depression.

What is Major or Clinical Depression?

Depression is much worse than simple unhappiness. Clinical depression is a "mood disorder." This means that a person's emotional state is abnormally low or sad, and the person cannot independently raise his or her mood. The chief symptom of major depression is a sad, despairing mood that persists beyond two weeks and impairs a person's performance at work, at school or in social relationships. This profoundly low mood state can be confusing because some of the symptoms of depression are behavioural, such as moving or talking slowly, while others are emotional and cognitive, such as feeling hopeless and thinking negative thoughts. This is very different from the physical symptoms of other illnesses, like the pain of a broken leg or the fever from a serious infection.

How is Depression Diagnosed?

In making a diagnosis, a doctor will ask you if you have experienced any of the following:

- changes in appetite and weight
- sleep problems, either sleeping too much or too little
- loss of interest in work, hobbies, people; loss of feeling for family members and friends
- feelings of uselessness, hopelessness, excessive guilt
- preoccupation with failure(s) or inadequacies and a loss of self-esteem; certain thoughts that are obsessional and difficult to "turn off"
- agitation or loss of energy; if you feel so restless that you cannot keep still, or if you feel too tired and weak to do anything
- slowed thinking, forgetfulness, trouble concentrating and making decisions
- decreased sexual drive
- a tendency to cry easily, or having the urge to cry, but are unable to do so
- suicidal or occasionally homicidal thoughts, and
- at times, a loss of touch with reality, perhaps hearing voices (hallucinations) or having strange ideas (delusions).

Depressive disorders can **vary in severity.** A person who suffers for two weeks or more with fewer than five of the symptoms of major depression is diagnosed with minor depression. When someone suffers with five or more of these typical symptoms for at least two weeks, this is called a "major depressive episode." For many people, however, their struggle with depression has persisted for weeks, months or even years before they visit a doctor or mental health professional. It is not uncommon for people to try to cope on their own while feeling their mood "slipping" or "dropping," until it reaches a point that feels intolerable. People struggling with depression may also find themselves to be much more sensitive to comments from others, and they get little or no relief when loved ones and friends try to cheer them up or offer support.

The length of a depressive episode is influenced by the person's ability or willingness to get treatment. A treated depressive episode may only last for two to six weeks; however, untreated episodes may last six to 18 months or longer. The average is about five months.

Depression and Bipolar Disorder

Depression also occurs in bipolar disorder or manic-depressive illness. Bipolar disorder is a mood disorder, but is characterized by episodes of depression, as well as episodes of **mania.** A person with mania will have an inflated or grandiose perception of his or her own importance or power. This can result in excessive involvement in activities that can lead to painful consequences (e.g. foolish business investments, shopping sprees, sexual indiscretions). People with mania also have less need for sleep, a pattern of very rapid speech and racing thoughts. During a manic episode, many people are unaware that their behaviour is unusual. Before a manic episode, however, people generally experience a **hypomanic phase**, where they exhibit some less-severe symptoms of mania (sleep disruption, a racy feeling), and are aware that they may be heading toward a full manic episode. This insight allows them to seek medical intervention and possibly avert a full-blown manic episode. While they share similar symptoms of depression, bipolar disorder and major depression are separate disorders requiring different treatment.

Different Kinds of Depression

Major depression is broken down into subtypes, each with a slightly different set of symptoms. It is important to receive an accurate diagnosis because different types of depression may respond better to different types of treatments.

Depression with Typical and Atypical Features.

In addition to the general features of depression, people with **typical symptoms** of depression tend to have sleep difficulties (trouble falling asleep, sleeping less than usual, and frequent waking through the night), decreased appetite, and weight loss as part of their symptoms.

People with **atypical symptoms** also share the general features of major depression, but they tend to struggle more with overeating and oversleeping. Evening rather than the morning tends to be the hardest part of the day. While a person with typical symptoms is generally unresponsive, atypical depression is characterized by "mood reactivity." This means that a person will be able to respond positively to something good or a pleasurable event, such as a visit from a relative, but will quickly become depressed again when the source of this pleasure disappears. These shifts up and down can be very difficult for both the person and family members.

Seasonal Affective Disorder or Seasonal Depression

Seasonal affective disorder (SAD) is a type of depression that tends to be affected by the weather and time of the year. Symptoms usually occur during the fall and winter, and the person feels better during the spring and summer. People struggling with SAD usually experience several symptoms, including several-months-long sad mood, increased sleep and increased appetite, characterized by carbohydrate cravings and weight gain.

SAD is more common in northern climates, where there is a significant decrease in the hours of sunlight over the winter months. While it is not unusual to experience some changes in mood during periods of decreased sunlight, people with SAD will experience much more severe symptoms, which interfere with their ability to work and relate well to others.

Post-partum Depression

While all types of depression may have multiple causes, post-partum depression follows a specific event, the birth of a child. Its onset may be related to biochemical and hormonal changes, emotional issues and social circumstances. About 13 per cent of women will experience this type of depression, which is characterized

by the major symptoms of depression that persist for four weeks or more and interfere with a mother's social and emotional functioning. Post-partum depression differs from the more common and less severe **post-partum blues,** which many women experience after childbirth.

Women who have had depressive episodes before pregnancy may be more vulnerable to developing a post-partum depression. Emotional issues, such as whether the baby was planned or unplanned, or whether the mother has support from the father and extended family, may also contribute to the onset of a depression. The responsibility of a new infant combined with the symptoms of depression can make this a very difficult time socially. Family and friends may wonder how the mother of a new baby could *not* be feeling joy on such a happy occasion. This may make the depressed new mother feel more isolated and uncomfortable in coming forward to ask for help.

Depression with Psychosis.

In some cases, depression may become so severe that a person loses touch with reality and becomes psychotic. Psychosis involves a break with reality in which a person experiences hallucinations (hearing voices or seeing people or objects that are not really there) or delusions (beliefs that have no basis in reality). Delusions may be paranoid, such as when the patient believes people are plotting against him or her. Hallucinations and delusions may be very critical or negative, and this may make the depressive state worse. When a depressed patient also has psychotic symptoms, treatment involves both antidepressant and antipsychotic medications.

Dysthymia

Dysthymia, or dysthymic disorder, describes a chronically low mood with some moderate symptoms of depression, such as: poor appetite or overeating, inability to sleep or sleeping too much, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions and feelings of hopelessness. If two or more of these symptoms last for two or more years, and a person does not experience a major depressive episode during this time, then a diagnosis of dysthymia may be made. While not as severe as major depression, dysthymia can interfere with a person's abilities at work, school or in important relationships. A person may have dysthymia, and then suffer a major depressive episode. This is known as **double depression.**

Personality Disorders and Depression

Sometimes, people with depression may also be told by their doctor that they have a personality disorder. What does this mean, and how does it affect the depression? Personality is what makes up the whole of the person, including thoughts, feelings, actions and relationships with others. A personality trait refers to the identifiable patterns of individuals, their usual ways of thinking and feeling, their habitual behaviours and their characteristic ways of relating to others.

A personality disorder is a statement about the quality of the person's personality traits. It means that the person is seen to have patterns of thoughts and feelings, behaviours and relationship styles that differ in significant ways from the culture in which he or she lives. Not only do these patterns differ from the norm, but they also lead the person to feel bad about himself or herself and interfere with his or her ability to function well at work and in his or her personal life.

When a person is diagnosed with a personality disorder, a specific name is given. For example, a person diagnosed as having a paranoid personality disorder will have problems trusting others in most parts of his or her life, even when there is no basis for suspicions. This pervasive distrust complicates the treatment of depression, because it interferes with the person's ability to develop and maintain relationships with others who might be able to provide needed support, including the doctor.

Many people have some of these personality characteristics, without any significant interference in their lives. For example, if someone is slow to trust, but is able to gain a belief in the goodwill of one or two friends or family members over time, we would think of this quality as being a personality trait, but not one that keeps the

person from engaging in a satisfying life. This person would not be diagnosed as having a personality disorder.

A few examples of the many types of personality disorders are: schizoid (great difficulty attaching emotionally to others), borderline (a pattern of unstable relationships, impulsive and sometimes self-destructive behaviour), and obsessive-compulsive (perfectionist, focused on minute details, to the exclusion of others' thoughts and opinions).

While personality disorders differ in how they manifest in each person, they all get in the way of people living comfortably with themselves or others. A person struggling with depression and a personality disorder not only needs to feel better, but also needs to learn new ways of relating to the world. This person will often be encouraged to receive pharmacotherapy and one of the talk therapies.

2 THE CAUSES OF DEPRESSION — CURRENT THEORIES

There is no simple answer to what causes depression, because several factors may play a part in the onset of the disorder. These include: a genetic or family history of depression, psychological or emotional vulnerability to depression, biological factors, and life event or environmental stressors. The fact that you may be undertaking one type of treatment, for example antidepressant medications, does not mean your depression is entirely biological. What it does mean is that often depression can be effectively treated by focusing on one area, such as the biochemistry in the brain. The type of treatment recommended is also often influenced by the severity of your depression. If severely depressed, it is difficult for a person to undertake the "talking therapies." As a result, medications may be the first stage of treatment, followed by psychotherapy as a second stage of intervention. Once you are feeling somewhat better, you may be better able to tolerate talking about other life problems that contribute to your depression.

Everyone has a certain number of "risk" or "vulnerability" factors. The more risk factors a person has, and the greater the levels of stress on the person, the greater the chance of having a depressive episode. This is known as the stress-vulnerability model.

THE STRESS-VULNERABILITY MODEL — RISK FACTORS IN DEPRESSION

1. GENETIC AND FAMILY HISTORY

A family history of depression does not necessarily mean children or other relatives will develop major depression. However, those with a family history of depression have slightly higher chances of becoming depressed at some stage in their lives. There are several theories to explain this phenomenon.

Genetic research suggests that depression can run in families. Studies of twins raised separately have shown that if one twin develops the disorder, the other has a 40 to

50 per cent chance of also being affected. This rate, though it is moderate, suggests that some people may have a genetic predisposition to developing depression.

A genetic predisposition alone, however, is unlikely to cause depression. Other factors, such as traumatic childhood or adult life events, may act as triggers. The onset of depression may also be influenced by what we learn as children. Some people may have been exposed to the depressive symptoms of their parents and have learned this as a way of reacting to certain problems. As adults, they may go on to use these strategies to deal with their own life stressors. Growing up with one parent who has been depressed puts a child at a 10 per cent risk of developing the disorder. If both parents were depressed, there is a 30 per cent risk. *It is important to note that these figures are actually lower than those for other types of illness that may be passed on from parent to child.*

If you have a family history of depression, it is important to educate yourself about the disorder and what you can do to protect yourself against it.

2. PSYCHOLOGICAL VULNERABILITY

Personality style, and the way you have learned to deal with problems, may contribute to the onset of depression. If you are the type of person who has a low opinion of yourself and worries a lot, if you are overly dependent on others, if you are a perfectionist and expect too much from yourself or others, or if you tend to hide your feelings, you may be at greater risk of becoming depressed.

3. LIFE EVENTS OR ENVIRONMENTAL STRESSES

Some studies suggest that early childhood trauma and losses, such as the death or separation of parents, or adult life events, such as the death of a loved one, divorce, the loss of a job, retirement, serious financial problems, and family conflict, can lead to the onset of depression. Suffering several severe and prolonged difficult life events increases a person's chances of developing a depressive disorder. Once depressed, it is common for a person to remember earlier traumatic life events, such as the loss of a parent, or childhood abuse, which make the depression worse.

Living with chronic family problems can also seriously affect a person's mood and lead to depressive symptoms. People living in emotionally abusive or violent relationships can feel trapped, both financially and emotionally, and feel hopeless about their future. This is particularly true of mothers with young children. The ongoing stress and social isolation associated with these family circumstances can lead to depressive symptoms.

Once a person develops a serious depression, he or she may need intensive treatment before feeling able to deal with the situation or life stressors that triggered the onset of the illness.

4. BIOLOGICAL FACTORS

Depression may appear after unusual physiological changes such as childbirth, and viral or other infections. This has given rise to the theory that hormonal or chemical imbalances in the brain may cause depression. Studies have shown that there are differences in the levels of certain biochemicals between depressed and non-depressed subjects. The fact that depression can be helped by antidepressant medication and electroconvulsive therapy (ECT) tends to support this theory.

Seasonal affective disorder (SAD) is a good example of how biology and personality may work together to influence the onset of depression. Researchers are investigating whether chemicals in the brain that regulate mood, sleep and appetite are affected by changes in levels of light. Research has found that people suffering from SAD seem to be highly sensitive to their own feelings and events around them, and that these reactions are amplified by seasonal changes in light levels.

For many patients and families, trying to understand the various theories that explain the onset of depression can be very confusing. While research has yet to fully explain the causes of depression, it is important to know that effective treatments are still available.

Common Questions about Depression

What about premenstrual syndrome (PMS), menopause and depression?

Changes in the hormonal cycle of women have been linked with symptoms of depression. Before their monthly periods (premenstrual stage), women can experience changeable moods, irritability, anxiety, sleep difficulties, as well as abdominal cramps, bloating and breast tenderness. For the woman with **premenstrual tension,** these symptoms may last for a few days and then go away. For the woman with **premenstrual syndrome,** the symptoms are more severe, and disrupt routine activities. A woman who struggles with both depression and premenstrual symptoms tends to feel much worse during this time of the month.

During **menopause,** a period of biological changes during mid-life, women must adjust to the effects of reduced levels of the hormone estrogen. The symptoms of menopause, such as hot flashes and profound sweating, may make it harder to function at work and in social situations. Menopause is also a time when women may have to deal with psychological issues and other life events — children may be leaving home, and aging spouses and family members may develop health problems. Menopause also represents the end of a woman's ability to have children. The physical and emotional stressors associated with menopause may contribute to the onset of depressive symptoms.

Can depression occur secondary to a physical illness?

Yes. In the medically ill, depression can occur in three different ways. Depressive symptoms may be the *result of another illness* that shares the same symptoms, such as lupus or hypothyroidism. Depression may be a *reaction to another illness,* such as cancer or a heart attack. Finally, depression may be *caused by an illness itself,* such as a stroke, where neurological changes have occurred. Regardless of the cause, depression in the medically ill is often treated with antidepressants and other therapies.

Is depression treated differently in the elderly?

Yes. Generally, elderly patients are given lower dosages because they are more sensitive to medication, prone to confusion, and may have more trouble tolerating side-effects. Potential drug interactions must be considered, because elderly patients are often taking medication for other medical problems.

How do alcohol, street and prescription drugs influence depression?

Alcohol, street drugs and some prescription medications can provide a temporary break from some of the symptoms of depression. However, this "self-medication" simply *masks* — and sometimes *worsens* — the symptoms of depression, which resurface when the substance use stops. In other people, depression can be *triggered* by abuse of alcohol and other drugs. In both cases, the substance abuse itself can lead to further health problems and can disrupt a person's ability to function. In most cases, treatment for the substance abuse is given first. If the depression persists, then the mood disorder becomes the focus of intervention.

Can people diagnosed with depression also suffer from anxiety?

Yes. As many as two-thirds of people who struggle with depression also have prominent symptoms of anxiety. Anxiety refers to excessive worry that is hard to control (apprehensive expectation). A person with anxiety feels restless or "keyed up and on edge." The person may also: tire easily, feel his or her mind going blank, feel irritable, or have tense muscles, trouble concentrating and sleep problems. The combination of depressive and anxiety symptoms can severely impair a person's ability to function at work, at school and in relationships.

If you have symptoms of both depression and anxiety, a thorough assessment should determine which of the two is the **primary** problem. The diagnosis will influence what kind of treatment is suggested. If it is difficult to tell which is the

primary disorder, a diagnosis of mixed anxiety-depressive disorder will be made, and treatment will be prescribed accordingly.

Many of the medications used to treat depression, such as Prozac (fluoxetine) and Anafranil (clomipramine) also treat anxiety. A person might also benefit from an anti-anxiety medication or **anxiolytic** such as Ativan (lorazepam). Cognitive Behaviour Therapy, which is a short-term, talk therapy described in the next chapter, has been very effective in treating both depression and anxiety. Other helpful treatments include relaxation therapy, and stress management techniques.

Even though loneliness and a lack of social supports can contribute to and maintain depression, depressed people seem to make their situations worse by often avoiding other people, thereby increasing their isolation. Why is this problem so common?

Most depressed people want to be left alone. The symptoms of depression make socializing and interacting with friends and family very difficult and even stressful. Additionally, depressed people often feel guilty about being depressed, and assume that their presence cannot be tolerated by others. Unfortunately, the resulting social isolation simply reinforces their depression. Part of recovery involves encouraging people with depression to gradually reintroduce themselves to social situations and structured group activities.

Should depressed people force themselves to continue with routines and activities?

If you are mildly depressed, but still able to carry on with some or all of your regular activities, you should push yourself to do so. If there is no routine to your day, you may dwell on problems and make your depression worse. If you are severely depressed and find it physically and emotionally impossible to carry out your normal activities, you should treat your depression the same way you would

treat a severe physical illness. Lower your expectations of yourself, set small goals for each day, and rest when your body needs it.

Can I return to normal after being depressed?

Most people are able to return to their previous level of functioning. For people who have suffered severe depressive episodes, or several depressive episodes, recovery can be a much slower process. Setting small, achievable goals, which may be far lower than those you would have set when you were well, will be an important first step in recovery. Professional support can help you develop a graduated plan for returning to work, school or volunteer activities.

Having had one depressive episode, will I be at risk of more periods of clinical depression?

Research suggests that people who have had one episode of depression have a 50 per cent chance of experiencing another episode at some point in their lives. After two depressive episodes there is an 80 per cent chance of relapse. *While these numbers may frighten you, the best protection against relapse is the understanding that depression is an illness that must be managed over your lifetime, even during periods of health.* This is why it is so important for patients, and their partners and families, to have information about the disorder and strategies for relapse prevention.

Common Questions about Acute Episodes

What should I do if I feel suicidal or feel like harming other people?

If you feel so depressed that you wish you were dead or you are thinking of ways to kill yourself or others, tell your doctor immediately. If you do not have a doctor, call you local distress centre or go for help to the emergency department

of the nearest general or psychiatric hospital. It is important that you have someone with whom you can talk and who has a more objective point of view. Suicidal thinking is the result of your "depression talking," and influencing how you see yourself and the world around you.

Will I be kept in hospital against my will if I am suicidal?

Most people who are suicidal recognize that they need treatment and find that hospitalization is a way to stay safe while their mood stabilizes. However, in most jurisdictions, if you do not recognize that you need hospitalization, or once admitted you want to leave in order to harm yourself or others, you can be legally certified by a doctor and prevented from leaving until your safety can be ensured. This certification will last only as long as is thought necessary. In most hospitals, patients may consult a rights advisor or have access to an appeal process to challenge this involuntary hospitalization.

Will I be completely well when I leave the hospital?

Probably not. Most patients are kept in hospital only in order to get their acute symptoms, such as suicidal thinking, under control and managed on medication. Then plans are made for patients to have ongoing follow-up from mental health professionals in the community. Because the process of recovery is slow, and it is important for patients to resume normal routines in their homes, hospital stays are kept as brief as possible. In addition, some people with depression may feel too upset by the institutional setting, being around other ill people, and being away from family and friends to benefit from an extended hospital stay.

3 Treatments for Depression

People with depression are often seen first by their family doctor or general practitioner. In milder cases, family doctors can assess and treat you as an outpatient with medication, counselling or both. They may refer you to other community resources (counselling services, drop-in centres).

If your depressive symptoms are more severe, a family doctor may refer you to a psychiatrist who can treat you as an outpatient or, if necessary, admit you to hospital.

In deciding what is the best plan for treatment, the doctor will consider the severity of your illness, events that may have triggered its onset, and, if applicable, previous treatments you have undergone.

The most commonly used treatments are pharmacotherapy (medications), psychoeducation, psychotherapy and electroconvulsive therapy. These treatments may be used individually or in combination. It is very helpful for a person's partner or family to learn about the disorder, either through reading materials, attending a family support and education group or talking with a mental health professional.

Psychosocial Interventions

Psychotherapy

Psychotherapy is often used along with medication to treat depression. Psychotherapy is a general term used to describe a form of treatment that is based on "talking work" done with a therapist. The aim is to relieve distress by discussing and expressing feelings, to help change attitudes, behaviour and habits that may be unhelpful, and to promote more constructive or adaptive ways of coping.

Successful psychotherapy depends on a supportive, comfortable relationship with a trusted therapist. Doctors, social workers, psychologists and other mental health professionals are trained in various models of psychotherapy, and work in hospitals, clinics and private practice.

There are many different treatment models of psychotherapy for individuals. **Short-term models** usually last up to 16 weeks. These therapies include interpersonal therapy and cognitive behavioural therapy. They are structured and focus on current, rather than childhood, issues. In interpersonal therapy, people examine their depression in the context of relationships that may be contributing to their mood difficulties. Cognitive behavioural therapy helps people examine how they interpret events around them, and how negative thoughts contribute to and maintain a depressed mood. In both therapies, the therapist takes an active role in guiding the discussions. Research has found these therapies to be very effective in treating depression.

Long-term therapy is less structured, and can last one year or more. The patient has more flexibility to talk about a variety of concerns related to both past and present-day issues. In general, the therapist helps the person to relate how current events trigger issues from childhood, which may now be impairing the person's performance in relationships, at work or at school. In this model, the therapist is less directive and gives minimal feedback, guiding the patient toward his or her own answers.

Therapy can also be provided in a group context. Meeting with eight to 12 other people who are struggling with similar issues can help reduce a person's sense of isolation. The kind of support, understanding and feedback found in group therapy may not be available within a person's own natural social network. Groups are generally led by one or two mental health professionals who guide the group process and offer structure and direction where needed. Some groups may be process oriented; that is, they focus on the issues the group members raise each week, rather than having a set agenda. Other groups may be quite structured, such as groups that follow cognitive behaviour therapy. In these groups, the members work through a step-by-step process, often guided by a manual that helps them to focus on dealing with attitudes and behaviours that contribute to and help maintain depression. Not all structured groups, however, require the use of a manual. Whether short- or long-term, psychotherapy can be used in combination with medication, and can help you to resolve issues that may be contributing to your depression and affecting your overall life situation.

How do I find a psychotherapist?

It is worth the time and effort required to find a psychotherapist with whom you feel comfortable. Speak with your family doctor about therapists in your area. These may include: psychiatrists (who provide both medication therapy and psychotherapy), general practitioner-psychotherapists, or private social workers, psychologists or other mental health professionals. Contact the general and psychiatric hospitals' outpatient departments in your area to find out if they offer individual or group psychotherapy. Your local mental health association may offer a referral service. Finally, do not overlook the network of "word-of-mouth" information available through self-help organizations and other people struggling with depression.

Psychoeducation

Psychoeducation is a process where people learn facts and information about depression, and also have an opportunity to talk about the feelings related to living and coping with the disorder. For example, it is common for patients learning about depression to experience strong feelings of fear or denial. Often, talking openly about these feelings helps people to deal with them and better adhere to a treatment plan that makes sense to them. Psychoeducation can occur in groups or in individual counselling with a doctor, social worker or other mental health professional.

Psychoeducation also helps family members or partners understand what the affected person is going through. They learn about the symptoms of depression, its treatment, what they can do to be helpful, and the limitations to the help that they can offer. The family can meet with the treating physician or therapist, or attend a family support and education group.

Finally, psychoeducation helps patients and families deal with their concerns about the stigma of mental illness. Although public education in recent years has raised awareness, there are still many people who do not understand depression as a disorder, and feel uncomfortable when it is discussed. It is important that patients and families have a safe place to discuss this issue and decide what information they wish to share outside of the family.

Family Interventions

Depression can have a profound impact, both on the people with the disorder and on their families. During an acute episode, partners and family members may have to assume the roles and responsibilities of the ill person. As a person recovers, partners and families may struggle to re-establish old routines. Sometimes, their feelings about what has happened, and fears about the future, make it difficult for things to "get back to normal." This may lead to marital or family conflict. Also, pre-existing family or marital stressors may have contributed to the onset of the depressive episode. In these situations, couple or family counselling can be very helpful.

Self-help Organizations

An important part of treatment and recovery both for people with depression and their families is the chance to meet informally with other people who understand their issues and challenges. Self-help organizations, run by clients of the mental health system and their families, are usually located in major cities with chapters in smaller centres; they often have newsletters that can reach people who live in isolated communities. Attending these groups can reduce a person's sense of isolation, and provides opportunities to learn from other group members' experiences. For many people, volunteering in these organizations and sharing the wisdom they have gained by living with depression can also be an empowering experience. Self-help organizations can be found through your local mental health association, your community mental health services, or your family doctor.

Biological Treatments

Medications

Antidepressant medications can relieve and resolve the symptoms of depression. Because depression is a complex disorder, many psychiatrists now specialize in the biology of depression and medication treatments. It is important to have a prescribing physician with whom you feel comfortable asking questions about medications, their effectiveness and their side-effects.

In the 1950s physicians discovered that Iproniazid, a drug used to treat tuberculosis, also elevated patients' moods. Iproniazid is a member of the MAOI family of antidepressants, which act by boosting neurotransmitters. Neurotransmitters are the chemicals in the brain that allow cells to communicate with one another, and in some cases regulate our moods. Further research has revealed that depressed patients do not have enough of the neurotransmitter serotonin, and that helping the brain to produce more serotonin seems to help lessen depression. However, the brain is a very complex organ, and serotonin is only one of over 500 neurotransmitters. More basic research is needed to discover how brain chemistry contributes to depression.

Even though many questions remain to be answered, medications are used successfully to treat depression, either on their own or in combination with psychotherapy. With early intervention, medication can prevent people from developing a severe depressive episode, and preserve their current coping skills. Medication also allows people to make better use of talking therapies than would be possible when they are acutely withdrawn and depressed. With more severe depressions, medication offers symptom relief and restores patients' moods to a more normal level, enabling them to return to regular routines and activities.

Common worries about antidepressants include the fear that one will become addicted to or dependent on medication. Antidepressants are not addictive and serve an important role in the treatment of depression. Many people hesitate to take medication, because they view reliance on them as a sign of weakness. This suggests that they view depression as a weakness in character, rather than a

legitimate medical disorder. Depression is an illness that, without treatment, can worsen significantly and even become life-threatening.

Even those patients who accept that medication is useful may find that unpleasant side-effects make following through with taking prescriptions difficult. Common side-effects from older antidepressants include dry mouth, constipation, difficulty urinating, and blurry vision. These side-effects are called **anticholinergic**. Although older antidepressants work as well as newer ones, patients often stop using them because of these side-effects.

For this reason, a group of newer agents have been developed. These drugs have fewer, and more tolerable, side-effects. These include headaches, insomnia, increased anxiety, sedation and sexual problems. An important part of the assessment and treatment process is for the physician to determine the medication that is best suited to the patient. Very few people will follow through with treatment if they experience intolerable side-effects. *If you are struggling with side-effects it is important to consult with your doctor, rather than abruptly stopping the medication. Though antidepressants are not addictive, sudden stoppage can lead to unpleasant reactions and possibly a poorer response to subsequent medications.*

To get the best effect from a medication, a physician will gradually increase the dosage of the medication to the highest level at which it will have a therapeutic effect. This is called **optimization**. Unlike other medications that relieve symptoms very quickly, antidepressants generally take two weeks or more to take effect. Usually, patients will experience side-effects first and symptom relief later, which may cause them to feel discouraged or disheartened. Side-effects can be offset by other medications, changes in the dosage of the drug, or if necessary, a change in medication. Though they may be annoying, side-effects are a sign that the drug is being absorbed by the body and is starting to work.

In addition to maximizing the dosage, a doctor may **augment** a medication, or boost its effect, by adding another medication. For example, the drug lithium may be chosen to augment the primary antidepressant.

Research suggests that patients will respond equally well to all classes of antidepressants, but may tolerate certain drugs better than others. It is common for individual patients to try two or more different medications before finding one that has a good effect and is well-tolerated. For some patients who are very **dose sensitive** (meaning that they react to even small fluctuations in the amount of medication in their system) it is important to take the medication at the same time every day. Once medication has relieved the symptoms of depression, it is often recommended that patients continue to take medication for up to one year or more, in order to avoid relapse.

Different Classes of Antidepressants

This section is a general overview of medications, listing examples of the generic names of drugs, as well as the Canadian trade name. Trade names will vary among countries. Further information can be found in David Healy's book, *Psychiatric Drugs Explained* (London: Mosby, 1993) or Jack Gorman's *The Essential Guide to Psychiatric Drugs* (New York: St. Martin's Griffin, 1997).

The Older Drugs

MAOIs — MONOAMINE OXIDASE INHIBITORS

Monoamine oxidase inhibitors, or MAOIs, such as Nardil (phenelzine) and Parnate (tranylcypromine) were the first class of antidepressants. MAOIs block the action of monoamine oxidase, an enzyme that breaks down some neurotransmitters in the brain. By blocking this enzyme breakdown, MAO inhibitors *increase* the number and the availability of neurotransmitters, which are helpful in the treatment of depression. MAOIs are still prescribed — often for the treatment of atypical depression.

It is important to know that MAOIs also affect a person's ability to digest and process foods that contain tyramine, foods such as aged and fermented cheeses, smoked meats and some beer. In large quantities, tyramine can be toxic and may lead to dangerous increases in blood pressure. The MAO enzyme protects us from

tyramine. Because MAOI drugs inhibit the action of MAO, patients taking these drugs must avoid these foods. This restriction means that patients usually take MAOIs only when other medications have not been effective.

CYCLICS

The second group of drugs developed for the treatment of depression were cyclic or tricyclic antidepressants, a group that includes Elavil (amitriptyline), Ludiomil (maprotiline) and Tofranil (imipramine). Because this group also tends to have more side-effects than newer, more refined drugs, they are not often a first choice for treatment. However, some patients find that these drugs are well-tolerated and very effective. Tricyclic medications tend to be more sedating and are associated with anticholinergic side-effects. Weight gain and dizziness may also be experienced with these medications.

The Newer Agents

SSRIs — SPECIFIC SEROTONIN REUPTAKE INHIBITORS

This newer group of drugs, including Prozac (fluoxetine), Paxil (paroxetine), Luvox (fluvoxemine) and Zoloft (sertraline), is usually the first choice for treatment of depression. These drugs generally do not cause the anticholinergic side-effects of the tricyclics. While these drugs are very effective, patients may experience initial side-effects, including nausea, stomach upset and headaches. Other patients may develop long-standing sleep difficulties, such as problems falling asleep or awakening throughout the night.

Other Classes of Newer Drugs

A number of newer medications have proven effective in treating depression. These drugs do not fit into any one category as they affect several different systems in the brain. They include Effexor (venlafaxine), Wellbutrin (buproprion), Manerix (moclobemide) and Serzone (nefazodone), and may have fewer side-effects than the MAOIs and tricyclics.

Frequently Asked Questions about Medications

Can antidepressants interact with other medications?

It is always important to ask your doctor about potential drug interactions with medications you are taking. If you are taking MAOIs, you should not take nasal decongestants, painkillers or other antidepressants. If you are taking blood pressure medication or are scheduled for surgery where you will receive an anesthetic, tell your doctor that you are on an MAOI.

Are medications safe in pregnancy and while breast-feeding?

Each woman's situation is individual and should be discussed with her treating physician. Research has found the newer antidepressants, such as Prozac, to be generally safe during pregnancy. The older drugs have not been well-studied, so any risk to the unborn child is not well understood. A further problem with the older drugs is their potential to lower blood pressure, which also happens naturally during pregnancy. The combined effect may be a health risk for the mother. While breast-feeding, antidepressants are not necessarily contra-indicated, because the body filters many impurities out of breast milk and only about 30 per cent of the medications can be detected. Given that an infant's organ systems are still immature, however, it may be wiser to bottle-feed the baby, or at least to supplement breast milk with bottle-feeding.

For any pregnant woman with a history of depression, the question of antidepressants during pregnancy usually comes down to a risk-benefit analysis. If not taking an antidepressant during pregnancy means a high risk of relapse and a serious depressive episode, which may affect prenatal care and a mother's ability to parent her newborn child, then the benefits of the antidepressant may outweigh the risks. This is particularly true with respect to sleep, which can be seriously disrupted in depression and become a major problem for pregnant and new mothers. Women

who feel uncomfortable remaining on medication may choose to try a period of being medication-free while they carefully monitor their mood. This is an individual choice for each woman to make in consultation with her doctor.

What about medications and the treatment of depression during menopause?

Depression in menopause can be the result of both hormonal and psychological factors. Antidepressants can help to ease the symptoms of depression. Hormone replacement therapy may also be effective. Supportive talking therapies and education-support groups can also help women to better understand this phase of their lives, cope with symptoms and adjust to other life changes that may affect their moods.

What about medications and driving?

Ask your doctor whether your medication may cause drowsiness. Depression itself can lead to fatigue and concentration problems, affecting your ability to drive. It is important to self-monitor, that is to keep track of these symptoms so you can make wise decisions about your ability to drive and stay alert to road conditions.

Do medications interact with caffeine?

Some MAOIs and SSRIs may have a mild interaction with coffee. Even if you are on a different class of medication, it is better to drink decaffeinated coffee and beverages. Caffeine itself can cause problems if you struggle with depression or anxiety. Depression disrupts sleep and caffeine, a stimulant, can make the problem worse.

What about complementary or alternative therapies?

Many people are becoming increasingly interested in using herbal or alternative remedies to treat depression. Some clinical trials in Europe have found St. John's Wort to be an effective treatment of mild depression. However, research has been limited and it is not easy to get information about the effectiveness of this and other herbal treatments. For North Americans there is the additional problem that the herbal industry is unregulated. This means that over-the-counter herbal remedies vary widely in consistency from manufacturer to manufacturer. If you are interested in herbal remedies, it is important to talk to your doctor. It is helpful to have a doctor who is knowledgeable about alternative therapies, because these herbs can interact with other medications you may be taking.

Many people also benefit from learning relaxation techniques and stress management strategies. Others find massage and acupuncture helpful in dealing with some of the symptoms, such as anxiety, associated with depression.

Light Therapy and Seasonal Affective Disorder (SAD)

Light therapy, spending one half-hour every day under specially designed light boxes, can provide relief for 65 per cent of those diagnosed with seasonal affective disorder.

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy, also referred to as "shock therapy," is a long-standing, effective and misunderstood treatment for acute depression. It has been both condemned and promoted in the mental health field and the media. In its early days, ECT was a more crude procedure that resulted in short- and longer-term memory loss. For most of these patients, however, memory problems resolved after six months.

Today, ECT remains the most effective treatment for major depression. However, it is usually seen as a last resort because of people's fears and misconceptions. Physicians usually treat patients with less intrusive methods, such as medication, before moving on to ECT.

ECT does not resemble the shock therapy portrayed in films such as *One Flew Over the Cuckoo's Nest*. Now patients are given muscle relaxants and a general anesthetic before a mild electrical shock is administered to one or both sides of the brain. There is no visible movement in the person who is undergoing treatment.

It is not clear why ECT works, but after about five courses, usually given every other day, most patients' moods begin to improve. Up to 12 courses or more may be offered, depending on the patient's response. Many severely depressed patients, who have been disappointed by the failure of medications to relieve their symptoms, find ECT "kickstarts" them out of an acute depressive state. The improvements can then be maintained with medications, occasional ECT treatments and psychotherapy or rehabilitative therapy.

4 RECOVERY AND RELAPSE PREVENTION

The Process of Recovery

People recovering from mild depressions usually resume their regular routines and responsibilities quite easily. Recovery from a more serious and lengthy depression can be a longer-term and slower process. A long period of illness can lower a person's self-confidence, making him or her feel insecure and vulnerable in situations that used to be familiar and comfortable. Depression can cause people to become quite dependent on those around them. People are often surprised at how frightened they are at the prospect of being independent and resuming their responsibilities.

It is important to recognize that these reactions are a normal part of the recovery phase of depression. *Give yourself permission to lower your expectations; you are recovering from a serious illness.* Just as you would increase activities gradually if you were recovering from a broken leg, a gradual increase in activities following a depressive episode will allow you to slowly take on responsibilities and build your self-confidence. Some people rush into a full schedule of activities in order to prove to themselves and others that they are fully recovered. This "flight into health" leaves them feeling overwhelmed and exhausted. If you have high expectations of yourself, or you like things to be perfect, you are likely to feel dissatisfied at your rate of recovery and feel hopeless and demoralized that things are not working out exactly right.

Remember that recovery is a process, not a discrete event. At first, you should ease yourself into familiar activities and have modest expectations. Predict that when you return to activities such as socializing and going to school or work, you will probably feel anxious. Allow yourself to make mistakes. A social worker, occupational therapist or nurse can help you plan a strategy for recovery that might include volunteer activities, pursuing leisure interests, school courses and part-time or eventually full-time work.

Effective Relapse Prevention

Unfortunately, people who have suffered a major depressive episode are at risk of further episodes. *It is important to use periods of wellness as an opportunity to actively prevent relapse.* Depression, like disorders such as diabetes, requires you to "self-monitor," or pay attention to how you are feeling, so you can catch early warnings of a possible relapse and possibly prevent a full depressive episode.

1. Become knowledgeable about the illness and treatment options. Read as much as you can about depression and its treatment; if there is something you do not understand, ask your mental health professionals.

2. To help prevent a relapse, monitor changes in your mood, develop a list of personal warning signs, and pay attention to activities that have a positive impact on your moods. When feeling better, pay attention to the variations in your moods. Don't ignore changes, such as sleep disturbances, or negative or hopeless thoughts, that may suggest a potential relapse. Pay attention to activities that help to stabilize or improve how you are feeling, and incorporate these into your everyday activities. For example, if walking your dog or visiting friends is helpful, make sure these are part of your structured routines.

3. If medication has been prescribed, continue to take it until your doctor advises you otherwise. Often, patients begin to feel better and stop taking their medication. Relapse is more likely if medication is discontinued too soon. Doctors usually recommend that medication be taken for six months to a year following a depressive episode. For some conditions, antidepressants may be recommended for several years. If you are experiencing side-effects, you may be tempted to stop taking your medication. Rather than making decisions on your own, work with your doctor around a treatment plan you can live with.

4. A healthy lifestyle is important: proper nutrition, exercise and good sleep habits. It makes sense to pay special attention to these areas if you are struggling with depression. Fatigue is worsened if you eat very little, or eat an unhealthy diet. Research has demonstrated that regular exercise can have a positive effect on mood.

If you are struggling with falling asleep, staying asleep or waking up early in the morning and being unable to get back to sleep, it is important for you to develop good sleep routines. Repeating these routines each night can help restore better sleep patterns. Try to go to bed at the same time each night. Avoid stimulating activities close to bedtime; plan on paying bills, completing work or having important discussions earlier in the day or evening. Many people find that relaxation exercises, easy reading or a warm, non-caffeinated beverage just before retiring are ways to promote a relaxed state of mind. Expect that it will take you some time to fall asleep and try not to anticipate sleep problems, as this will only add to your anxiety. For some people, a sleep medication provides relief and allows them the much-needed rest they have been deprived of due to depression.

5. Think about whether any features of your personality may lead to depressive thinking. If you tend to view circumstances and events around you in an overly negative way, if you worry a lot, if you have trouble expressing your feelings, or if you tend to be inflexible or perfectionistic, you might benefit from psychotherapy. Through psychotherapy you can learn to address these issues, and build on your strengths.

6. You cannot avoid stress, but you may learn to cope better by adopting new strategies. Many people with depression tend to use only one coping strategy. For example, they hide their worries and avoid dealing with problems. This may work in some cases, but not in others. Where possible, try different strategies. Deal with some problems as they happen. Avoiding them allows stress to build up. Be realistic about your stress-breaking point. Work toward recognizing what aspects of relationships in your life might be unhealthy and, if possible, try to avoid situations that may trigger relapse.

7. Remember that meaningful relationships and social support are important for your sense of self-worth and happiness. Spending too much time alone can contribute to depression and relapse, yet the feelings of depression often make people want to isolate themselves. Strong social networks and social support can serve as a buffer against depression. Try to avoid spending too much time alone and work toward maintaining contact with your social network.

Who you tell about your depression is a very personal choice. While the stigma of mental illness is certainly much less than it once was, it remains a concern for many people. As a buffer against relapse, however, it is important to have at least one person you can rely on and in whom you can confide. Along with family and professional support, many people struggling with depression find that self-help and support groups are a valuable part of their social network.

8. Try to develop a well-balanced life with enough time for work, family and friends, and leisure activities. It might seem easy at first to escape from your depression by focusing entirely on one area, such as work, or a hobby. Eventually however, this coping strategy may not work, and you will need to develop other aspects of your life. It is important to keep in contact with all the facets of our lives, such as school, work or volunteer activities, family and friends, and hobbies. As you recover, investing energy into several areas will help you develop a more balanced and satisfying lifestyle, which will help you to avoid relapse.

9. Get follow-up treatment. It is important to have both a family doctor and, if necessary, a psychiatrist who can follow you regularly. Depending on your needs, you may also benefit from individual, group or family therapy, or a support group to help you deal with the impact depression has had on your life. If you start to feel depressed again, contact your doctor immediately. Help may come in the form of a visiting nurse, occupational therapist, or social worker who can provide extra support when necessary. Early intervention may help to prevent or minimize the severity of another depressive episode.

10. Finally, be aware that it is common for patients, once recovered, to silently worry about relapse. Think about establishing an emergency plan with your family, partner or a friend just in case you begin to feel unwell again. This plan will include knowing who will notify your doctor and take you to appointments, who will notify your school or work, or look after your children, and who will ensure your rent and bills are paid should you need to be hospitalized. You may feel less anxious about the future if you know that a back-up plan exists.

5 HELP FOR PARTNERS AND FAMILIES

Seeing a loved one struggle with depression can make people feel sad, concerned, frightened, helpless and anxious. You may experience guilt, anger and frustration. All depressive episodes are upsetting, but the patient's first one will probably be especially confusing. You may not understand what is happening and why the person is not getting better on his or her own. Without information about depression, you might assume your relative is lazy, give well-meaning advice and become frustrated and annoyed when he or she does not act on it. If your relative talks about suicide, you will understandably live with a great deal of worry.

Families and partners need to get as much information as possible about depression. Knowledge and understanding will improve your ability to assist and support your loved one, deal with your own feelings, and explain the situation to extended family, friends and colleagues. Information is available from the treating physician, social worker or other mental health professionals. In addition to this publication, there are several books written for patients and families. These are usually available through public libraries. Many communities also have self-help and support groups, and psychoeducational groups designed to meet the needs of families.

How to Relate to the Depressed Person

Family members often do not know how to talk to a depressed person. They may be afraid to ask too many questions and inadvertently upset their loved one. At the same time, they do not want the ill relative to feel they are not interested or are avoiding him or her.

Try to be as supportive, understanding and patient as possible. Just recognizing that depression is an illness can help your relative to feel less guilty about his or her impaired functioning.

Tips for Communication:

1. Speak in a **calm, quiet voice.**
2. **Stay focused on one subject** at a time**.** It may be difficult for your relative to concentrate.
3. If the person is quiet and withdrawn, break the ice with **neutral, non-threatening statements,** such as "It seems a bit warm in here."
4. **Be patient and wait.** It may take a while for your loved one to respond.
5. **Your ability to listen is a valuable resource to your relative or friend.** Depression causes people to talk at length about how bad they feel, yet they may not be ready to discuss solutions to their problems. Listening and letting the person know, in a neutral manner, that you have heard what he or she has said, is a valuable and supportive contribution. **You do not have to offer immediate solutions.**
6. **If your relative or friend is irritable, you probably need to slow down, lower your expectations and use a very neutral approach.** Neutral comments about the weather, what you are making for dinner or other routine subjects are the safest way to develop a dialogue. **Listen** for opportunities to acknowledge or add to your relative's responses. At these times, conversations about important decisions or issues are unlikely to be productive. You may need to plan to discuss important issues at a later date.

Moderately depressed people may be able to hear your helpful suggestions, but be unable to act on your advice. Avoid quizzing them about what made them feel depressed. Do not blame them for the way they feel, or tell them to snap out of it. This will only reinforce their guilt, loneliness and isolation. Often, depressed people cannot identify what made them depressed or what will be helpful.

If your partner or relative is severely or more chronically depressed, it is normal for you to experience his or her company as particularly draining. Brief, frequent contacts are often the best way to relate to the severely depressed person. If your relative is hospitalized, family members might take turns visiting the patient.

When you are visiting, make a special effort to listen to what the depressed person is saying, rather than telling the person what he or she should do. Avoid longer visits as they are tiring for both the patient and the visitor.

Care for Partners and Families

Whenever someone suffers from a serious illness, it is natural for family members to feel worried and stressed. In an effort to spend time comforting or helping their loved ones, family members may give up their own activities. Over time, they may become isolated from their own network of friends, or find that most of their normal routines and activities have been replaced by the demands of caring for their depressed relative. Often, they are well into this situation before they realize how emotionally and physically drained they have become. This stress can lead to sleep disturbances, exhaustion, or chronic irritability.

It is important to recognize these signs of stress in yourself and look after your own physical and mental health. Recognizing your own limitations and making time for yourself are key elements to "self-care." Ensure that you have a good support system of reliable friends and relatives. Think about who you want to share the details of the situation with. Mental illness is a difficult thing for some people to make sense of, so it is understandable if you want to be selective and choose only people you know to be supportive.

Consider having your own professional support and joining a self-help organization or relative support program, which may be offered at a local hospital or community mental health clinic. Preserve your interests outside of the family and apart from your ill relative. Acknowledge and accept that sometimes you will have negative feelings about the situation. These feelings are normal and should not be a source of guilt.

Family Concerns about Acute Episodes

1. Compliance with Treatment

While many people are eager to seek treatment for depression, others are reluctant to admit their difficulties. Some people with depression worry that admitting to their depressed feelings is a sign of weakness, or that they will be stigmatized for having psychiatric problems. Others try to cope on their own and do not realize until they are acutely depressed that they have a disorder that can be treated.

If you are worried about a loved one who appears depressed, but is not currently receiving treatment, just letting him or her know that help exists may be enough to get the person to seek treatment. For some patients, it is a long and bumpy road to acceptance that they have a disorder that must be managed over their life span. Some people must endure several depressive episodes before they accept consistent help from doctors and therapists. As a family member, it can be very difficult to watch this process without trying to repeatedly convince the patient that he or she "should take your medication" or "go and talk to your doctor." Repeated attempts to convince and cajole can lead to heated arguments and power struggles. If you are very close to the depressed person and you feel he or she may not be open to your observation that something is wrong, it is sometimes more effective to have another trusted person approach your relative.

2. The Suicidal Relative

People who are depressed to the point of suicide may refuse treatment because they feel so hopeless and worthless. In such a case, you or another trusted person should insist that the depressed person see his or her doctor or go to the emergency department of a local hospital. Most people will agree to go to the hospital; however, if the person refuses, you can then ask a doctor to make a house call and certify that the person must be hospitalized. If this is not possible, a visit to a justice of the peace, who issues an "order to certify," will allow emergency personnel to take your relative to the hospital.

Although it is a painful and difficult decision, it is sometimes necessary to involve the police in order to get an ill person to the hospital. Family members often feel overwhelmingly guilty about this decision, even when it is necessary to protect the person's life. It is important to remember that when people threaten suicide, they are usually making a plea for help, which should be taken seriously. Suicidal thinking is usually a temporary emotional state during which a person needs to be in a place of safety.

Once in hospital, if your relative is quite ill and impaired, it is sometimes better for both the patient and the family if visits are frequent, but short. Patients who are acutely ill do not benefit from long conversations where they can become overwhelmed as they ruminate, or repeatedly focus on their feelings of hopelessness and negativity. Frequent, brief contacts allow you to stay in touch with your relative, and reassure him or her that you remain supportive.

For some patients, being in hospital is very difficult to tolerate. For this reason, they may wish to leave the hospital before the professional staff feel their mood and behaviour are stabilized. For family members, this is particularly difficult as they can foresee the problems at home if the person becomes acutely ill again and requires hospitalization. Some patients will respond to the concerns of friends and family and agree to stay longer in hospital. This is more easily accomplished if there are clear goals to be achieved during the admission. For example, it might be helpful to concretely state that a patient must be stabilized on medication and connected with a day program or community therapist before discharge.

Most jurisdictions in North America have mental health legislation that only permits involuntary hospitalization of people if they threaten to harm themselves or other people, or cannot care for themselves. Many ill people who would benefit from hospitalization do not meet these criteria and therefore may leave the hospital against medical advice.

In these situations, try to negotiate with your relative *when* it might be best to leave the hospital. What must be accomplished during the admission for you to feel it is safe for the person to return home? Could these issues be discussed in a

discharge planning meeting with your relative, the doctor and any other professionals who work with him or her?

Sometimes, you can slow your relative down by saying that you need this meeting to take place before consenting to his or her returning home. Families often feel guilty insisting on these conditions because they are worried the patient will feel rejected. However, the result of premature discharge and poor discharge planning is frequently a relapse in the illness and a more complicated situation.

3. How You Can Best Support Recovery

Once stabilized, you will likely observe your relative make slow, but steady improvement. Over time, he or she may want to discontinue medication, because of the side-effects, or psychotherapy, because of the time commitment involved. Your support in encouraging your loved one to remain in treatment can be very important. Premature termination of medication can contribute to relapse. Reducing or stopping medication should be monitored by a physician. Psychotherapy works best if the client and the therapist mutually agree that the person's emotional work is complete or the agreed-upon number of sessions has been reached.

Family members, partners and friends are important figures in a patient's support network. "Just being there" and keeping up an interest in the depressed person is an important contribution to the patient's recovery process. Once recovered from their illness, patients have commented on how much they appreciated the presence and tolerance of their families and friends.

The recovering person will gradually enter a transitional phase where previous responsibilities are resumed. He or she might benefit from some help with making decisions about which first steps to take. Try to do things *with* the person, rather than *for* the person. Giving your opinion before you are asked may be experienced as controlling by your relative. Encourage the person to be as active as possible. Recognize that your relative is an independent adult, who may choose activities or behaviours with which you disagree. Try not to say that the person has made an incorrect choice just because he or she is ill. This can be very hurtful and can complicate your relationship.

As your loved one's health improves, you should increasingly treat him or her as a well person. This means including the person in family activities, discussions and responsibilities around the house. Some families address and resolve problems through loud arguments and debates, and openly express hostility and anger. Research suggests that patients recovering from depression are at greater risk of relapse if they are exposed to this kind of conflict. As family members or close friends, you need to be sensitive to the needs of your recovering relative and understand that he or she might not be able to manage the highly charged emotions associated with conflict and arguments. Other ways of dealing with family disputes, such as family counselling, may be good resources to consider.

4. Being Ready for a Relapse or a Crisis

Patients and their families often avoid talking about acute crises because these events are uncomfortable to acknowledge and awkward to discuss. However, the best way to handle a crisis is to know what to do before it happens. While the focus should be on maintaining wellness, some planning for a possible crisis can create a sense of security for the ill person and his or her support system.

If possible, when your relative is well, discuss what you should do if he or she should become ill or suicidal. Could you both attend an appointment with the doctor to discuss your relative's condition and the possibility of a crisis? If your relative became ill, would you have permission in advance to contact his or her doctor? Would you have consent to take the person to the hospital, and which hospital is preferred? If your loved one is acutely ill, would you be allowed to make decisions? Could you put the conditions of an agreement in writing to ensure that these instructions are followed?

A good working relationship with the treating physician and a prearranged plan can help to contain an emergency situation.

6 EXPLAINING DEPRESSION TO CHILDREN

Explaining mental illness or depression to children can be awkward and difficult. To protect their children, the depressed parent and the well parent (if present) may choose to say nothing and try to continue with family routines as if nothing were wrong. While this may provide a short-term solution, over the long term it can leave children confused and worried about the changes in behaviour that they have inevitably noticed.

Children are sensitive and intuitive, and quickly notice when someone in the family has changed. If the atmosphere in the family suggests that the subject should not be discussed, children will draw their own, often incorrect, conclusions. Young children, especially those of pre-school or school age, often see the world as revolving around themselves. If something negative or difficult happens, they assume they did something to cause it. For example, if a child disobeys a parent and gets into trouble, and the next morning the parent is depressed, the child may assume he or she caused the parent's depression.

To explain mental illness and depression to children, you provide them with as much information as they are mature enough to understand. Toddlers and preschool children are able to understand simple, short sentences, without much technical information. School-age children can process more information, but may be overwhelmed by details about medications and therapies. Finally, teenagers are generally able to manage most information, and often need to talk about their impressions and feelings. They may have questions about how open they should be about the situation, and concerns about the stigma of mental illness. Sharing information with them provides an opening for further discussion.

It is helpful to cover three main areas:

1. The parent or family member behaves this way because he or she is sick. It is important to tell children that the family member is ill with a sickness called depression. Depression makes people sad, sometimes for no reason. They might cry a lot, sleep all day and have trouble eating or talking to people. Sometimes depression takes a long time to get better, and our efforts to cheer the person up do not work.

2. Reassure the child that he or she did not make the parent or family member sad and depressed. Children need to be reassured that they did not cause their loved one to be sad and unhappy because of something they did or did not do. This is a frequent assumption children will feel guilty about. Depression needs to be explained as an illness, just like having the chicken pox or a bad cold.

3. Reassure the child that the adults in the family and other people, such as doctors, are trying to help the depressed person. Looking after the depressed person is an adult responsibility, and not something the child should worry about. Children need the non-depressed parent, or other trusted adults, to serve as a buffer against the effects of a parent's depression. Talking about their feelings with someone who empathizes with how hard it is to see their mother, father or relative suffering is very helpful. Many children are frightened by the changes in their parent. They miss the time previously spent with this parent. Participation in activities outside the home is helpful because it exposes children to other healthy relationships. As the ill parent recovers, gradually resuming family activities can help restore the relationship between the children and the ill parent.

Both the ill and the well parent should talk with the children about explaining the illness to people outside the family. Support from friends is important for everyone; however, depression can be difficult to explain, and some families are concerned about the stigma attached to mental illness. The level of openness you and your children are comfortable with is a very individual choice.

Finally, some parents struggling with depression find that their symptoms of irritability, impatience and disorganization make it difficult to tolerate the boisterous activities and noise that are part of children's everyday play and routines. It may be necessary to take special measures to protect against events that could trigger irritability in the ill parent and cause him or her to be abrupt or short with your children. You may need to plan time for the children to play outside the home, or arrange for the ill parent to rest for part of the day in a quiet area of the house.

Once recovered, it is helpful for the parent who was ill to explain his or her behaviour to the children. The recovered parent may need to plan some special times with the children, to re-establish the relationship and to reassure the children that he or she is again available and interested in them.

CONCLUSION

This handbook has provided an overview of the nature of depressive illness, its potential causes, and the various treatments available to people diagnosed with this disorder. Depression is an illness that can be successfully treated and managed. Given its recurrent nature, it is important for those diagnosed with depression to have information on how to find treatment, and how to use periods of wellness to preserve their health and avert relapse. This information is also important for family members who may feel unsure how best to help their depressed loved one. By reading this guide, you have taken an important step toward empowering yourself with knowledge about depression, and developing management strategies to deal more effectively with the challenging situations associated with the disorder.

GLOSSARY

ANTICHOLINERGIC – a group of common side-effects of the older group of antidepressants, including dry mouth, constipation, difficulty urinating and blurry vision.

ANTIDEPRESSANTS – medicines used to reduce the symptoms of depression.

ANXIETY – an emotional state characterized by excessive worry, apprehension or fear of impending actual or imagined danger, vulnerability or uncertainty. In a more acute form it can include intense fear and discomfort, with symptoms such as a pounding heart, sweating, shortness of breath, nausea, dizziness, and fear of losing control.

ANXIOLYTICS – also known as anti-anxiety medicines, used to reduce anxiety symptoms.

ATYPICAL DEPRESSION – a type of major depression in which the person has mood reactivity and can be cheered up by positive events and has at least two of the following: increased appetite or weight gain; increased sleep; leaden paralysis and feels easily rejected.

AUGMENTATION – the addition of another medication to boost the effect of the primary medication.

BIPOLAR DISORDER – also known as manic-depression, includes the occurrence of one or more manic or hypomanic episodes and usually the occurrence of one or more major depressive episodes.

COGNITIVE BEHAVIOURAL – a time-limited psychotherapy that focuses on how thoughts influence mood and how some patterns contribute to depression.

CYCLOTHYMIC DISORDER – a long-standing mood disturbance that involves recurrent periods of both depression and hypomania. Although similar in nature to bipolar disorder, the mood swings are not as severe or as prolonged.

DELUSION – a false, fixed belief not shared by your culture, such as believing your thoughts are being controlled by forces outside you. A paranoid delusion includes feelings of suspiciousness and grandiosity.

DYSTHYMIC DISORDER – a type of mood disorder whose main characteristic is a chronically depressed mood that lasts for most of the day, for the majority of the time during a two-year period.

ELECTROCONVULSIVE THERAPY – a treatment procedure for severe depression, which involves passing a controlled electric current between two metal discs applied on the surface of the scalp.

EUTHYMIC STATE – normal, stable mood synonymous with recovery.

HALLUCINATION – a false sensory experience, such as seeing, hearing, tasting, smelling or feeling something that does not really exist.

HYPOMANIA – a state characterized by a high mood and overactivity, but not as extreme as mania.

INTERPERSONAL PSYCHOTHERAPY – a time-limited psychotherapy that focuses on the aspects of relationships to others, which are linked to the depressive episode.

MAJOR DEPRESSIVE DISORDER – (or unipolar depression) involves one or more major depressive episodes. These include symptoms such as depressed mood, loss of interest or pleasure, significant changes in weight or sleep, loss of energy, diminished capacity to think or concentrate, feelings of worthlessness or excessive guilt, and recurrent thoughts of death or suicide.

MANIA – a state characterized by an unusually high mood, irritability, overactivity, excessive talkativeness, racing thoughts, inflated ideas of self, and financial extravagance.

MENOPAUSE – a period of biological changes in women as they cease to menstruate and have reduced levels of the hormone estrogen.

MOOD DISORDERS – disorders that have a disturbance in mood (typically depression or mania) as the predominant feature. The two main categories are unipolar depression and bipolar disorder, or manic-depression.

MOOD STABILIZERS – medicines used to treat symptoms of depression, mostly used in bipolar disorder.

NEUROLEPTIC – antipsychotic medicines used to reduce psychotic symptoms.

OPTIMIZATION – gradually increasing the dosage of a medication to the highest level where it will have a therapeutic effect.

PERSONALITY DISORDER – an enduring pattern of thoughts, feelings and behaviour that differs in significant ways from the culture in which the person lives. This pattern is pervasive and inflexible, begins in adolescence or early adulthood and causes distress or impairment.

PHARMACOTHERAPY – treatment of symptoms of disorders with medications that operate by altering the chemical balance in specific systems in the brain.

PREMENSTRUAL SYNDROME – severe and disruptive premenstrual stage with changeable moods, irritability, anxiety, sleep difficulties, abdominal cramps, bloating and breast tenderness.

POST-PARTUM DEPRESSION – a depressive episode following childbirth, usually due to physical and hormonal changes.

PSYCHOEDUCATION – a process where people get information about disorders and have an opportunity to talk about the feelings they have about the illness.

PSYCHOTHERAPY – a general term used to describe a form of treatment based on talking with a therapist. Psychotherapy aims to relieve distress by discussing and expressing feelings, to help you change your attitudes, behaviour and habits, and to develop better ways of coping.

PSYCHOTIC DEPRESSION – a major depressive episode in which the person loses touch with reality and may have hallucinations or delusions.

RELAPSE PREVENTION – managing the mood disorder by medication and/or psychotherapy or other supportive strategies to help the person remain well.

SEASONAL AFFECTIVE DISORDER – a type of depression that tends to be affected by the amount of daylight and the time of the year, usually occurring in the fall and winter.

SUPPORT GROUP – a group of people who have a common interest or situation, such as a diagnosis of depression, who meet regularly to share ideas, feelings and community resources information.

TRANQUILLIZERS – medicines used to sedate.

UNIPOLAR DEPRESSION – another name for major depressive disorder.

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