Throwing Light on a Dark Problem

English version translated by Mark Agius

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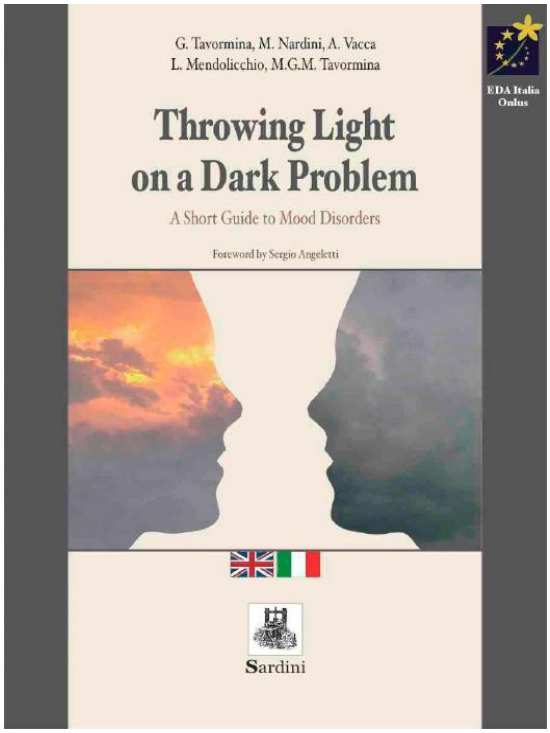

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Foreword

It is an sutbtle, refined play on words,evoking psychological, photographic and biochemical ideas to refer to depression as a dark problem.

This booklet for patients and their carers, who must share the patient's debilitating illness, has been developed from the experience of international experts , who have called it 'Throwing light on a dark problem'.

'If I know you then I know how to face you', and hopefully how to overcome you.

It is about how to face, step by step and day by day the increase and decrease of the symptoms of depression.

But now this authoritative booklet brings to light the most modern scientific knowledge about depression , making it available to those who suffer and fear depression.

As we know, depression is becoming more common. Therefore this useful booklet should also become more available: indeed it is already being made available as an international version.

Sergio Angeletti

Introduction

We are always struck by news events involving young mothers and their children, episodes of suicide and homicide, often inexplicable, old persons, adults and adolescents who do not hesitate to carry out extreme actions. Maybe we had not noticed their suffering, and we had not understood their requests for help, not understanding that they were caught up in the vortex of Depression.

So what is depression, this malign, debilitating force which infiltrates us with no obvious external signs.

We have stigmatised as weak those affected by it, and that was not difficult, in a world which thrives on competition.

The World Health Organisation believes that depression will be the third most important cause of disability and that its incidence will grow rapidly in particular among women between the ages of 15 and 44.

Ten years ago we asked ourselves what we could do to concretely help persons affected by depression. Medication helps, but alone it is not enough. It is necessary to break the viscious circle of fear, embarrasment, shame and social isolation which inexorably wears down the depressed person, who feels unable to respond to the modern competitive culture, who feels he can no longer have normal sexual relations, who cannot have a constructive relationship with his children, and who is unable to deal with the daily stress of the workplace.

It seemed necessary to educate about depression, describing this pathology which is seen as an expression of weakness.

It was necessary to say that depression is an illness like others, and that it can be treated.

Thus we developed Depression Day: a day dedicated to inform health workers and the wider public about this pathology which is increasingly present in our society.

Together with colleagues from 10 European countries we chose the first of October each year to be that day.

If you have a broken leg, it is easy for you to be aworded the status of being ill. With an unseen depressive pathology it is much more difficult to be awarded the same status!

If depression is not recognised then it cannot be treated!

Postpartum depression is a clear example. Certainly hormonal factors are involved, but it is also true that the symptoms of anxiety and stress are often undervalued because they are considered normally associated with looking after a new baby.

What can we do?

We should recognise the causes of depression and the factors which prolong it.

We should insist on proper education of health professionals.

We should increase education and information about the illness.

This small volume is a concrete contribution to increasing knowledge of the illness and its terminology and causes as well as a support for health professionals as well as a guiding light in the dark tortous tunnel of mood disorders.

One should understand them better in order to be able to defeat them.

Vincenzo Costigliola

President of EDA

1) What are mood disorders?

Mood disorders are alterations in affective tone and behaviour which can be interpreted as an exaggerated reaction to emotions which are experienced on a daily basis.
The most respected international experts tend nowadays to talk about mod disorders in their entirety, thus implying that "**when the mood is not good it is in fact unstable**".
About one person in five tends to suffer from instability of mood.
This instability manifests itself in episodes of depressed mood, alternating with irritability and restlessness or with episodes of mania or euphoria, as well as other symptoms. Al of this has led international experts to coin the term "*bipolar mood disturbance*" and "*bipolar spectrum*".
To better understand the instability and variability of mood, let us imagine that it is made up of *three components: mood, flux and content of ideas, and motor functions*. If we think of all these three components oriented downwards, then we have a depressed mood, a slowing down of thinking, and little energy or wish to move; this is a *depressed state*. If instead we consider all three components to be oriented upwards, then we have a euphoric mood, many rapidly flowing ideas, and hyperactive movements, hence such a mood is referred to as *manic*.

2) What is Bipolar Affective Disorder?

Bipolar Affective Disorder is characterised by the alternation of a depressive mood state with a manic (or hypomanic) one. When a person does not completely transit from one state to the other (in other words when he is neither completely depressed nor completely manic), he is said to be in a **mixed state**.
In many cases the patient's symptoms are not easily recognised and the patient may be unwell for many years before he receives a correct diagnosis and adequate treatment.
The typical age at the beginning of the illness is between the ages of twenty and thirty, but it may occur at any age. There are no differences in incidence between men and women, except that women tend to suffer more frequent depressive episodes and fewer manic ones.
The first episode may be either manic or depressive. When the first episode is manic, the patient tends to suffer from more manic episodes than depressed ones.
One should not, however, confuse the normal "ups and downs" which we all experience in our lives with the severe experiences of bipolar disorder, which may ruin interpersonal relationships, cause patients to lose their job, and in extreme cases may even lead to suicide attempts.
Unlike the normal "*ups and downs*" which we all experience in our lives, symptoms of bipolar disorder are characterised by a marked intensity, duration and persistence, and are often very severe.
"*Manic-Depressive Illness distorts your state of mind and your ideas, causes you to commit terrible actions, destroys your basis for rational thought, and often undermines the will to live.*
It is a biological illness but it becomes manifest at a psychological level. It is unique among illnesses in the advantages and pleasures it gives, but in its wake it brings enormous suffering and even suicide. I am fortunate not to have died of this illness, fortunate to receive the best available medical treatment and fortunate to have the friends, colleagues and family which I have".
(Kay Redfield Jamison, An Unquiet mind, TEA, 1995, pag 20).

3) How does Bipolar Affective Disorder Present ?

There are many ways in which bipolar Affective Disorder can present, because the symptoms may vary across the whole spectrum of mood [from manic to depressed] and may also vary in quality and number of symptoms as well as in intensity. This has led experts to propose the concept of the bipolar spectrum, implying a large number of symptoms, of which the typical bipolar picture is only the tip of the iceberg. The most common presentations are as follows;

- **Bipolar I Affective disorder**: this used in the past to be called Manic Depressive Psychosis; It mainly affects men and is characterised by manic and depressive episodes of equal seriousness.
- **Bipolar II Affective Disorder**: this is the most common. It mainly affects women and is characterised by depressive episodes which are more severe than the manic episodes.
- **Cyclothymia**: These patients suffer continual variation in mood of an intensity and duration which are greater than is to be expected physiologically.
- **Mixed States** (mixed depressive states or dysphoria): there is the contemporaneous presence of irritability, tention, sadness and emotional lability,with frequent somatic symptoms (headaches-migraine, colitis, muscular tention)
- **Depressive Episodes** (major or recurrent): long and persistent (or recurrent, often seasonal) depressive episodes which can be severe.

4) What are the symptoms of Bipolar Illness?

Bipolar illness causes dramatic changes in mood, from euphoric states with or without irritability to an absolute sadness with a total loss of hope. Thes changes in mood are linked with intense variations in energy and changes in behaviour.
The euphoric episodes are called **episodes of mania**, those of sadness **episodes of depression**. Periods with the contemporaneous presence of euphoria/irritability and tention/sadness are referred to as **mixed states**.
Between the episodes of mania and depression, the mood may return to normal, and these times are called periods of euthymia (euthymic phases).

The Depressive phase.

In the depressive phase, the mood is sad, unhappy, melancholic and hopeless and helpless. The patient experiences less energy and is easily tired.Motivation is less, the patient lacks initiative and often gives up doing things because he/she feels he/she will not succeed, or feels that there cannot be a happy outcome.The patient has difficulty in formulating thoughts, making plans , ans he/she has the impression that he/she is not capable and has lost the ability or spirit to act.
The most common symptoms of the depressive episode are:

- Sadness, pessimism and desperation;
- Poor self esteem: a feeling of failure and loss;
- Loneliness and boredom: loss of interest in everything and a feeling that he/she no longer feels anything for the persons he/she loves;
- Poor motivation, no get up and go;
- Absent or poor sexual feeling;
- Sleep disturbances (insomnia) and poor appetite (eating too little or too much);
- In the most serious cases there are suicidal thoughts and a wish to die.

The Manic Phase.

The manic phase may be considered the opposite of the depressive phase: during the depressive phase the patient feels unhappy, without self esteem and energy while in the manic phase the patient feels exactly the opposite. He/she feels especially happy, special, brilliant and without limits. The patient is very excited, his energies are greater, his thoughts are fast, original and rich. He has a positive, sometimes domineering, exhibitionist or provocative attitude. He perceives the environment as close to him, objectives as accievable, success positive or certain obstacles as irrelevant, while people who do not agree with them are criticised or assaulted. In some cases the patient may become psychotic, with symptoms of grandiosity, mysticism or persecutory delusions.

The Most common symptoms of the manic phase are:

- being excessively optimistic, feeling brilliant, and feeling omnipotent and able to achieve anything;
- having rapid thoughts and rapid speech: a person in manic phase speaks very rapidly and is difficult to understand;
- tending to speak in a way which is difficult for the listener to understand (the patient moves from one argument to another without any clear logical connection, and sometimes rhyming is the only link between thoughts – flight of ideas);
- sleeping very little at night without noticing tiredness and having the impression that the patient has an inexhaustible reserve of energy;
- perceptions are stronger: sounds appear louder and colours more vivid;
- having a series of grandiose projects which are however not very realistic, in which the person feels that they have special talents and that they are destined to succeed, so that he starts many projects and never concludes any of them;
- feeling completely disinhibited, so that wheras previously the patient was prudent and careful, he is now without any inhibitions, and says what he thinks without considering the consequences, and is very disinhibited sexually, (which can lead to unwise, imprudent and embarrassing behaviours);
- spending unwisely and buying excessively and unwisely, so that in this phasepatients can accumulate huge debts and invest money unwisely;
- in the most serious cases, the patient can be excessively aggressive: the person in manic phase may be litigious, troublesome, and can become physically violent;
- In the most serious cases, the patient may have delusions of grandiour, and may be convinced that they have special powers, extraudinary capabilities, be loved by a celebrity, etc…

5) What are the main signs and symptoms which cannot be ignored in order to achieve early diagnosis of these illnesses?

Making a correct Diagnosis of Bipolar Affective Disorder is a key issue of public health importance. This diagnosis is often not considered, is often underdiagnosed, not treated or treated badly, with the serious consequences which may arise because of these failures; deterioration of interpersonal relationships, loss of work, family crises, substance abuse, impulsivity, self harm or harm to others (family tragedies, suicide, rape, etc).

Early Diagnosis is therefore essential to effective treatment. A very useful clue to the diagnosis is its presence, in one of its forms, in at least one family member.

In order to make *a diagnosis of mania or hypomania*, there must be established a distinct period of abnormal and persistent rased mood with characteristics of expansiveness or irritability. The mood disturbance should be sufficiently severe to compromise the activities

of study, work, or capacity to relate socially.
For a diagnosis of depression it is necessary that there should be a period of at least two weeks duration of loss of interest in or enjoyment of all or most activities.
The depression must be severe enough to cause a change of appetite, of body weight, sleep disturbance, difficulty in concentration, as well as a feeling of guilt, inadequacy, or despair; there can also be thoughts about death or suicide.
It is important to exclude the possibility that these symptoms may be caused by drugs or by other physical pathologies. The doctor should carry out a full physical examination and appropriate tests, and a neurological examination may be necessary.
Sometimes a person may only experience episodes of euphoria/ hypomania/mania, or only periods of depression, alternating with periods of stable mood. If only episodes of depression are present, the illness is usually called **Major Depressive Disorder**, (and termed *recurrent* if the problem occurs periodically or cyclically).

6) What are the difficulties in recognising and treating this illness ?

The main difficulty in the recognition and treatment of this illness usually occurs in the manic phase. Usually, in fact, a person who is in a manic phase refuses to be treated. He does not accept that he is ill , indeed he claims never to have felt better in his life. The sufferer from bipolar disorder often experiences a sense of liberation during the manic phase. During the depressive phase, persons feel inhibited, a failure, with no prospects, and then, when he becomes manic, these feelings suddenly vanish. During manic episodes, persons feel sure of themselves, free to do whatever they want,without any limits. Everything seems easily achievable, and even the most anbitious projects seem realisable.

During the manic phase the faculties of judgement and criticality are weakened and all inhibitory checks disappear, and with them all doubts and anxieties. However, once this psychological state of exhaltation is ended, the person who suffers from Bipolar Affective Disorder must confront all the consequences of their unwise and embarrassing actions (for example having acquired debts of several million euros, having resigned from work in a moment of anger, having been sexually promiscuous without taking any precautions,etc).
Often *depressive phases* follow manic phases, and the situation is completely the opposite. Mood is very low, with the sensation that nothing can interest the patient or give him pleasure. The meaningfulness of life is lost, and life appears profoundly unhappy.Sleep and appetite may increase or decrease. The patient feels easily tired and lacks energy, and has great difficulty concentrating. Depressive phases can become so severe that they can lead to self harm or suicide.
Illicit drug and alcohol abuse is often associated with bipolar illness and can make it much more severe.
Diagnosis of bipolar disorder cannot be made by using blood tests or imaging examinations of the brain. Diagnosis is based on symptoms, and on the longitudinal history of the length and development of the illness, and on the family history, if it is available. Therefore it is extremely important to tell the specialist all the symptoms, thoughts, behaviours of the patient, and also the episodes which have occurred in the lives of other members of the family. For this reason, it is advisable to be accompanied to the consultation by a family member or a friend who can tell the doctor about the patient's attitudes and behaviour over the last few months.

In Summary, the following points need to be born in mind:

- a family history of bipolar disorder or suicide;

- previous eppisodes of prolonged hypomania/euphoria/irritability;
- first presentation (or recurrence) during specific seasons (during the winter or during summer);
- previous episodes of cyclothymia (changes in mood in a constant or continuous fashion);
- the presence or association of anxiety symptoms including panic or obsessional symptoms;
- the presence frequent headaches (migraines), muscular tention, gastrointestinal disturbances, changes in appetite;
- a history of substance abuse (be it periodic or continuous).

Sometimes, during severe episodes of mania or depression, **psychotic symptoms** may occur. The most Common are:

- sensory hallucinations (hearing voices, seeing things which do not exist, unusual smells which others do not smell…),
- delusions (false opinions, firmly held, which cannot be explained by logic or by the persons cultural value).

Persons with bipolar disorder who present with psychotic symptoms may receive *an incorrect diagnosis of schizophrenia*.

7) Can Children and Adolescents suffer from Bipolar Disorder?

Bipolar Disorder can have an early onset and can present in children and adolescents.
It is important to distinguish between normal developmental crises and a real mood disorder. This may be easier if one of the child's parents also suffers from bipolar disorder.
Unlike the adult presentation, in childhood and early adolescence the illness presents with rapid, sudden and unjustified changes in mood which may be observed sometimes several times a day. The children are often very irritable and aggressive and may have distructive tendencies and sometimes extreme moments of happiness and joy which are often unjustified.
In the latter phase of adolescence the illness has the same characteristics as those in the adult. One may observe the tendency to indulge in risky situations and a continuous challenge to authority (parents, teachers, etc.).
The illness is frequently associated with the use of illicit drugs and alcohol in order to deal with a great deal of mental suffering which the young persons do not understand and which they find it difficult to discuss with adults.
Suicidal thoughts are also common and should not be ignored. The help of a child psychiatrist or a psychiatrist should be sought urgently.
The idea that "he who speaks about killing himself usually does not do it" and that the patient's aim is simply to attract attention is, to our mind, a fundamental mistake. By doing so one is undervaluing the message which the person is giving out and undervaluing the riskiness of his ideas. If he is left alone, he becomes irritable and disappointed, since he feels misunderstood. Instead it is important to offer him attention, and words of comfort and encouragement. A person who has found the courage to confide his feelings regarding suicide to someone else has already gone beyond his own possibilities of coping with the problem: he needs our help and support.

8) What are the causes of Bipolar Affective Disorder ?

The exact causes of bipolar affective disorder are not known.
Most research about this suggests that it is caused by a biochemical inbalance in certain

parts of the brain, which causes changes in the systems for communication between neurons.
Neurons use neurotransmitter chemicals to communicate between themselves.
For example, the monoamine neurotransmitters (serotonin, noradrenaline, and dopamine) and the excitatory aminoacid neurotransmitter glutamate, or the inhibitory aminoacid neurotransmitter gaba-amino-buteric-acid (GABA).
The medications which are used to treat Bipolar Affective Disorder, or *Mood Stabilisers*, work on these systems.
Other studies suggest that bipolar affective disorder is the consequence of **malfunction of the intracellular messenger systems** (the motor systems within the cells) in certain specific parts of the brain.
It is possible that the development of bipolar disorder occurs through a process of '*sensitisation' or 'kindling'*.
This theory suggests that the first episodes of the illness are brought on by stressful events (berievement, loss of a job, chronic illness, etc.), but that each episode causes brain changes which make the next episode more likely, till eventually the episodes end by developing spontaneously.
This process was first described to explain epilepsy, and this might explain why certain anticonvulsant medications are also effective in treating bipolar disorder.
Traumatic life events such as serious losses, chronic illness, drug abuse or serious financial problems can bring about episodes of this illness in predisposed subjects.
There is clearly a **genetic predisposition** to bipolar disorder: it does in fact present in families. Over twothirds of persons affected by this pathology have at least one direct relative who suffers from episodic variations in mood or major depression.

9) Is Bipolar Affective Disorder Treatable?

Bipolar Affective Disorder is a chronic illness, however most persons who suffer from this illness can achieve a basically stable mood with adequate treatment.
Long term preventive treatment is almost always necessary.
The basic model for the treatment of this illness is that it is not enough to treat the manic or depressive episode, but it is most important to treat the actual illness.
A therapeutic strategy which includes medication and psychotherapeutic interventions is considered optimal for treating this condition over time.
There are situations when there can be major changes in mood despite adequate treatment. In these situations it is important, as soon as the first signs appear, to contact your psychiatrist, who may be able to prevent the new episode from developing fully by adjusting the dose of medication. There are also other factors which may be important, such as stressful life events, disappointments, excessive use of coffee, alcohol, illicit drugs or other stimulants, serious irregularities in sleep, poor quality of life, some medications, concommitent illnesses, trauma and bereavement.
Psychotherapeutic interventions are aimed at helping the patient to recognise better his own way of functioning and to accept it, to distinguish himself and his personality from the illness, to improve his management of stress, and so indirectly to reduce the factors which induce relapse.
"*In an indescribable way, psychotherapy returns one to health. It somehow gives sense to the confusion, it puts a break on feelings and thoughts which frighten one, it restores control and hope and the possibility to learn from all this… No pill can help me to face the problem that I do not want to take pills; in the same way, no type of psychotherapy is able, by itself, to prevent my mania and my depression. I need both".*
(Kay Redfield Jamison, Una mente inquieta, TEA, 1995).

10) Which Medications are indicated for treatment ?

The medications used to treat bipolar disorder are usually prescribed by psychiatrists. The medications used are:

- **mood stabilisers** (these are the medications of first choice, and are essential in order to control the disturbance and the changes of mood in either direction: these medications include lithium and the antiepileptic medications);
- **atypical antipsychotics** (these medications are used because they have mood stabilising properties);
- **antidepressants**: these should only be used during the depressive phase of the illness in conjunction with mood stabilisers in order to reduce the risk of the patient switching to the opposite pole (mania) and to prevent (or not encourage) the development of the illness towards a reduction in the length of the symptom free periods and a consequent increase in the number of 'cycles of illness'.

11) What psychosocial and psychotherapeutic interventions are available to treat the illness ?

These interventions are usually carried out be psychologists and other professional persons who have been specifically trained in the technique, and they should always be carried out in collaboration with the psychiatrist who is treating the patient.
The most frequently used technoques used in the management of bipolar disorder are:

- **Cognitive behavioural therapy,**
- **Psychoeducation,**
- **Cognitive –Constructive psychotherapy,**
- **Family Interventions,**
- **Psycho-social Rehabilitation.**

Cognitive Behavioural therapy is amongst the most effective therapies for this illness. It can help the patient by increasing his understanding of and capability to manage his illness and can help the doctor understand better the development of symptoms so that a more effective treatment regemen can be chosen.
This approach also includes ***psychoeducation for both the patient and his family*** so that they can better understand the different phases of the illness. Often the family undervalue certain symptoms, such as insomnia, euphoria and irritability, redefining them in terms of peculiarities of character, or as aspects linked with the will of the person, the influence of bad company, or a regulated life.
Psychosocial rehabilitation is a cardinal element in the treatment of the patient, who, freed from the symptoms of the illness, and with a good understanding of the physiological expression of his own being, reoccupies his place in society not only because he feels better and can return to work but also because he is able to deal himself with his own difficulties, to deal with the distructive elements of the illness, and to live in such a way as to manage his own illness. Useful rehabilative techniques for the treatment of mood disorders include song therapy, dance therapy, art therapy and sport (in particular running, swimming and team games). The effect of the group dilutes personal tensions, facilitates new challenges, and encourages co-operation and synergy of action in order to achieve a common goal.

12) What are self help Groups ?

Self Help Groups or Mutual Aid Groups for patients and their families are small groups of persons, who suffer the same problems, and who meet together regularly to share their experiences, and to offer each other understanding and encouragement.
One can find information, support, solidarity and friendship. Self Help Groups have been approved by WHO.
Self help groups are an essential part of a new culture and a new approach to mental health problems based on a new concept of encouraging patients and their families to understand and take responsibility for their illness.

13) Where should one go to treat Depression and Bipolar Affective Disorder ?

Every person who suffers from Bipolar Affective Disorder should be followed up regularly by a psychiatrist who has specific training in the diagnosis and treatment of this illness.
Proper management of mood disorders is fundamental to the quality of life of the patient and his family. This can be done by understanding and applying some basic parameters:
- the psychiatrist should be the doctor in charge of care;
- a good therapeutic alliance with the patient is essential in order to ensure that the patient follows the treastment plan;
- depression is an illness which causes significant biological changes: hence it is not a sign of weakness or lasyness, and cannot be overcome by an act of will alone *(I must do it by myself!)*.

When the early signs of illness appear, one must consult one's doctor, either at a Mental Health Centre or at a private clinic in order to receive appropriate preventive measures, care and rehabilitation to overcome your mood disorder.

Treatment for your mood disorder means a good quality of life.

Do not suffer alone. Inform the appropriate persons!

Do not let shame and prejudice prevent you from getting help.

Do not believe that there is nothing that can be done.

Remember that together we can win!

Do not stay alone in your sadness!

Remember that one can fight depression

and WIN !

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Depression
Day

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