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EC86-416 Depression : The Common Cold of Mental Health

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DEPRESSION: THE COMMON COLD OF MENTAL HEALTH

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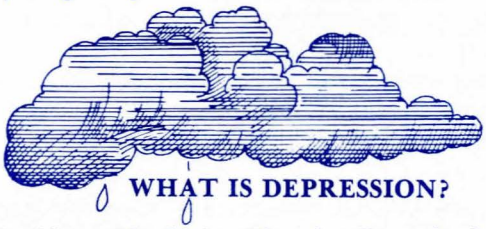
Take comfort, all you of have the blues or the blahs or whatever you call your down times. Periods of depression are a normal part of living, but there are times when some people are not able to handle depression alone and need professional help. Taking the viewpoint that depression is a part of living puts the problem in perspective. It gets away from foolish notions that depression is automatically a sign of personal weakness or mental illness.



WHAT IS DEPRESSION?

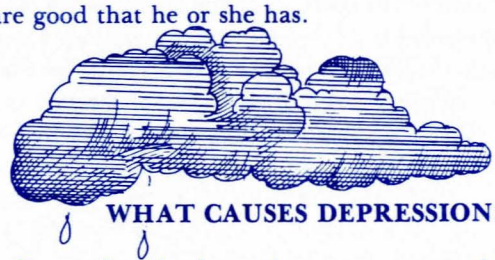
The blues. The blahs. The pits. Down in the dumps. Under the weather. Just about everybody has a favorite phrase to describe a depressed mood. In some ways, the condition is almost like an object: we know its location is "down," and its color is blue, gray, black, or sometimes no color at all. But for the most part, people regard depression as a feeling, a mood, an emotion. As such, depression is a normal human experience; an unavoidable part of existence. Sadness, grief, frustration, discouragement, and negative reactions to loss and change are the dark threads interwoven in life.

When does depression cease to be a normal condition and become abnormal? In some cases, the boundaries are unclear, but increasingly, physicians view a combination of intensity, severity, and duration of depressive symptoms as the benchmark for clinical depression. Usually clinical depression is signaled by a depressed mood and/or loss of interest in usual activities. Symptoms may include appetite, weight, and sleep disturbances; hyperactivity or lethargy; anxiety, crying, slowed thinking, suicidal tendencies, feelings of guilt, worthlessness, and hopelessness. When these symptoms persist more than two weeks, a clinical depression may be occurring.

Depression is likely to hit us when things in our lives go awry; it is said to occur when our emotional and physical resilience mechanisms fail us temporarily. It is important that we first recognize when we are sliding into depression and not be embarrassed by it. Probably the sickest people, if you can use the word sick at all, are those people who cannot acknowledge a depression.

It is estimated that a third of marriage failures may be caused by one partner being depressed and no one recognizing it. When you are depressed, you are likely to be easily offended, irritable, withdrawn, and disinterested in sex. Those behaviors can be very hard on a marriage.

For youth, there is mounting evidence that many harmful behaviors can accompany depression—suicide attempts, drug abuse, anorexia, bulimia, and juvenile delinquency. These may be methods that young people use to try to cope with the anguish they feel. So if depression can be curbed, many of these problems might disappear as well. In this broad spectrum of behaviors, we're talking about problems to which affective disorders seem to be linked. This is not to say that every kid with these problems has a major affective disorder. But, the odds are good that he or she has.



WHAT CAUSES DEPRESSION?

Researchers in depression seem to resemble the blind men examining the elephant: the biologist may have hold of the tail, the social researcher may have grabbed an ear, the psychological theorist has embraced the foot, but how these parts fit together is unclear. And, to carry the analogy even further, researchers suspect that as the parts connect they will discover not just one elephant, but a whole herd: different sizes, shapes, behaviors.

Not only are there many causes for depression that interact in different ways for different people, but there are a number of different "depressions." No one condition, event, or factor is thought to be absolutely responsible for

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depression; instead, a number of influences converge along what has been called a "common pathway" that produces the depressive syndrome.

The concept of **risk factor** is particularly important when looking at depression. A risk factor is a condition which increases the likelihood of a person developing a particular disorder. Since current findings have shown that women are twice as likely to develop major depressions as men, being a woman is a risk factor. Those at risk for depressive symptoms include women, youth, the lower classes, single people, and those who have recently experienced an interpersonal loss.

We once believed that severe depression was an adult illness. We thought that adolescents didn't develop "real" depression, they just had "adolescent adjustment problems." Now, however, we feel that idea is dead wrong. Adolescents, even children, suffer from major depression as much as adults do. Research is only beginning, so estimates vary of how many young people suffer from major affective disorders, which include depression and manic-depression, an illness characterized by elation, hyperactivity, or irritability, alternating with depression. Depending on the age of the youngster and how the illness is defined, the estimates can range from one to six percent. Depression for adolescents is serious and appears to be growing. One study shows that the percentage of older teenagers with major affective disorders has increased more than five times over the past 40 years. It is felt that when depression starts in childhood or adolescence, it is likely to have a genetic link.

In studies of family inheritance, it is extremely difficult to separate heredity from environment—the nature versus nurture controversy. Current scientific thinking favors a complex intermixture of heredity and environment. For instance, if a woman is depressed, and her mother, aunt, and grandfather were all depressed, does that mean that depression is "in the genes," or that she has learned the depressive behavior by living in a depressing household?

There are behaviors that may run in families independent of genes. The propensity to let off steam by quarreling loudly, or, conversely, to endure difficulties in silence, for example, may be learned and carried over from generation to generation. Non-genetic conditions such as poverty or wealth may also "run in families," influencing behavior. Another issue is assortative mating: people who are clinically depressed, or who come from families with this type of history, may tend to marry other people with similar conditions and family histories.

In everyday life, depression is having a negative attitude about the world, other people, and most of all—OURSELVES! There are many ways we can be down. Each of us no doubt has his or her favorite blues song to express despair or being down. One of my favorites is "I'll never love again, I'll never smile again." It fits the model of depressive symptoms well. What does it feel like to hit rock bottom? I once had a patient who shared, "I wish I was dead and in hell with my back broke." A staff member who came in to discuss a blue mood in her life talked for a half hour and then summarized her feelings by saying, "Mother loved me, but she died."

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There's nothing quite so devastating as feeling unloved, unneeded, uninvolved. Probably most of us have experienced the blues many more times than we have the common cold. We say we are down in many ways. You don't have to be famous to be depressed; it happens to everyone.

You may be depressed if .....

—you have little energy to do anything.
—you sleep more than usual or have insomnia.
—you feel sad; nothing seems good.
—you have a diminished ability to think and/or concentrate.
—nothing seems worth feeling good about.
—you feel a sense of hopelessness.
—you feel you can't do anything right so . . . why bother?
—you have eating disturbances (appetite and/or weight loss or gain).

Think about a time when you were depressed or down. What did it feel like? What was the situation? How did it happen?

ELDERLY—may have feelings regarding physical problems, damaged self-esteem, retirement, declining income, loss of loved ones, loneliness, lack of involvement.

MIDDLE YEARS—most likely group for depression; goals and dreams unattainable, children leaving home and becoming independent, etc.

YOUNG ADULTS—struggle with intense job and family responsibilities; into a search for personal and job fulfillment.

ADOLESCENTS—social stress, rapid physical changes, wide mood swings, not old enough to be adults, too old to be kids.

CHILDREN—even babies—relate to family conflicts and pressures; get depressed. Dennis the Menace told his dog, 'ole Ruff, recently, "I'm just a kid and you're just a dog."

MARRIEDS—may experience depression more often than singles— interpersonal conflicts and double binds; many unfilled dreams.

WOMEN—twice as likely as men; may experience more social stresses due to lack of fulfillment.

Typically, the cause of depression deep down is a great loss or a lost dream . . .

-lost a job; -lost a lover; -lost a wife; -lost a lot of money or a career; -lost_____, you fill the blank.

You're angry because of that loss. Anger then turns into depression. When you felt your lowest, was it the result of a loss of some kind?

One of the following factors may also be involved:

-personality type; perhaps you have learned to be self-critical or you grew up in a "self-critical" family.

-environmental influences; social, work, family influences;

-biochemical functions; perhaps as a side-effect from a medication or the imbalance of mood-influencing chemicals;

-genetic patterns; biochemical tendency in your blood line;

At their worst, blue feelings are the kind that lead to severe depression which can cause a personal crisis or suicide. Not many of us talk about suicide-because we don't talk about it we don't know much about it. And yet, in Nebraska, suicide is one of the leaders in the cause of death among 14 to 24-year age olds. It ranks with accidents.

GETTING HELP

Depression is widely misunderstood; is often ignored and left untreated; often unrecognized to the point that everyone suffers. But, it can be treated **successfully.** Depression is not the most common emotional disturbance; anger and fear are. However, people do not seek help for anger and fear as often as they do for feelings of guilt, despair, and depression. This is probably because the latter two are recognized as the disturbances with which psychotherapists often work, where getting mad or worried is thought to be normal.

The poor souls who hated themselves, lived a life feeling inferior, or felt life wasn't worth the effort were routinely medicated, sometimes shocked (without any understanding of how they became depressed), and were offered some form of psychoanalysis, as the psychotherapeutic method of choice.

That time is past. It is now possible, with new methods, for the depressed person to learn how to get over this pain, practically forever. The re-education that we all have before us is how we make ourselves depressed, how we keep that depression alive, and how to prevent or monitor future depression.

When you are feeling down, first ask yourself if you are depressed. Second, see if you can link the depression to recent or past events in your life. Finding what tipped you into the blues can help you work your way out of them. Then, you should evaluate how disabling your depression is. If it interferes with your work, your personal or love life, you should seek professional help. If you find that you cannot answer these questions, you need outside help.

A little **emotional first aid** can help. What do you do when you have a temperature of 104 degrees? You take some action! When the mood is dark blue, we also need some action. There are clear guidelines—very clear guidelines on what to do.

Drugs can help. Anti-depressant drugs sometimes are called for, and people should not be embarrassed to use them. A treatment pattern which includes medication and psychotherapy coupled with self-help groups or "self-help people" is often the treatment of choice. We sometimes can help ourselves by sharing how we feel with a friend or family member who is supportive. Many people move up and out of the blues by finding something that gives their morale a boost.

Things to Remember . . . for Emotional First Aid

-one person who cares can offer a temporary lifeline—which is what's needed since the crisis is usually time-limited.

-encourage the person to talk about his or her feelings of hopelessness and despair.

-respond with some concern for what the person is saying—"That's a tough situation," or "Things are really falling apart for you . . . You're really unhappy, aren't you?" It's not necessary to try to cheer him or her up. Just show that you take his or her feelings seriously and wish to help.

-don't be afraid to talk about suicide. Talking frankly about it lets you assess how serious the situation is.

-if the person is thinking of suicide, it's important to see if he or she has a definite method or plan in mind. Understand that most people will cooperate to prevent carrying out the plan.

-it's best not to tell a person how much she or he has to live for—this gives the person a chance to set up counter arguments in her or his mind. And, don't ask a mother what her children would do without her—in her disturbed state, she might feel that she should take the children's lives as well as her own. The same for a man raising children alone or a daughter/son caring for their elder parents.

-stay close (or alert someone else to stay close) until help is available and the risk has passed.

-know your community resources for the potential suicide victim and for treatment of both youth and adults with depression.

ACTIONS. . . see a physician or mental health professional; talk things over; examine your feelings; take a break; get exercise; avoid extra stress and extra involvements.

Most of us have never been trained in giving emotional first aid. We know more about rescuing a drowning person than we do about helping someone through an emotional crisis.

Remember—in most cases, suicide can be prevented;—in most cases, depression can be alleviated or cured.

At some time or other most of us feel like failures. We've lost a love, a dream, a job . . . There are lots of ways to get F's—FAILURES. We need A's.

ACTIVITY . . . . ACCOMPLISHMENT . . . . ASSOCIATION

Activity: walking, shopping, music, involvement; your choice.

Accomplishment: cleaning the house; cleaning the car; learning something new; finishing an assignment or task on time; you do it.

Association: with people who care; with "paid people-lovers;" with sincere friends . . . "friends can be good medicine;" with good listeners and people who respond with concern; with people you can let into your life.

Some people can improve their ability to handle depression and bounce back if they become more creative. Dismiss the idea that creativity is the exclusive province of people who can write plays, paint pictures, and compose a concerto.

All people can and should be creative with their own lives. To be creative you must be flexible and be able to move back and forth between intuition and logic. When mulling over a problem, consider many alternatives. Let ideas simmer along. In this way you can defer making critical judgments until you have a better perspective.

In using creativity, you need to ask yourself the right question and look at the alternatives. Persons considering divorce, for example, would be better off considering whether they would enjoy living alone rather than whether they would like to be divorced. Creative thinking can help you work your way through problems and see that you are not trapped forever by things as they are.

POSTPARTUM DEPRESSION

Postpartum depression sometimes happens to mothers shortly after their babies arrive.

The mother who is ill-prepared practically, emotionally or both runs the greatest risk of developing postpartum depression. "Baby Blues" can strike anyone, regardless of educational or social background.

Mrs. Brown dreamed of having a beautiful little girl, a "doll" for whom she might sew, knit, and crochet. She had the little girl, but found that having a child was not like playing with dolls with all its delightful drama and freedom from responsibility.

Mrs. Smith prided herself on her organizational and planning skills. She expected to be as organized and efficient in mothering as she had been in her business life. First, the baby came late, disrupting her plans for having her husband take his vacation at the scheduled time of delivery. Second, her planned schedule of taking care of her house, husband, and baby didn't work out. The baby cried at night, disrupting her rest and consequently her efficiency during the day. After a month, she became convinced she could not take care of her baby's needs. She hadn't considered she had studied and trained for her professional life, but had not known what motherhood was all about. She had expected the baby to fit into the family's schedule without a ripple. Like many other couples, she and her husband weren't prepared for the time and cash drain the baby required.

Not only is the mother affected by her reaction to childbirth, but the child is also affected. Mrs. Brown's daughter reacted to her mother's disappointment and suffered from bedwetting almost into adulthood.

Mrs. Smith's son became an anxious, compulsive, and often fearful child. He reflected his mother's need for perfection and order to an extreme.

If mothers could discuss their expectations and anxieties before or during pregnancy their problems and their children's problems might be considerably changed. This holds true for everyone, even for those mothers fortunate enough not to have serious problems.

Psychoanalysts recognize that the first year of a child's life is crucial to its development. The early mother-infant relationship is fundamental in the psychological and social characteristics of the child—that shape the child's personality and emotional health. It provides the foundation on which the bricks of succeeding years can either be securely attached or in danger of falling apart.

This knowledge may be frightening to the expectant and new mother. Properly understood, however, it can point the way to preparation for parenthood.

A healthy mother has the best chance of producing a healthy child. Preventive medical procedures have been instituted: prenatal care, alternative methods of delivery and postnatal attention to both mother and child help in this area.

It is just as true that an emotionally healthy mother has the best chance of producing an emotionally healthy child. A child who arrives in a happy, stable home has the best chance of becoming a happy, stable individual.

Most prenatal classes mothers attend prepare them for the physical factors of childbirth and infant care, but not for their own emotional needs after delivery.

Mothers-to-be should be told what the arrival of a baby

might mean to them. Schedules often go "out the window." Feelings of being trapped in a house are common. Being tired is almost universal.

Husband-wife relationships often change. Instead of two—three people now make demands upon each other. The dynamics of the marriage relationship also changes. Many husbands feel that they are playing a secondary role after they become fathers. One middle-aged man said, "I lost my wife when I had children." Obviously, he was not prepared for the demands children make. He appeared to have expected a mother replacement in his wife—when she had to mother the children, she couldn't mother him and he had resented it. Years later, he found he had two maladjusted children, who felt rejected by their father and he wondered why.

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Fathers are highly important in the development of their children—including their interaction with babies in the first few months. Fathers have two functions in modern families. First, they need to interact with the children and help with the day-to-day care of them. Second, they need to be the emotional systems for the mothers of the babies.

Research studies show that children strain a marriage relationship. Much of the strain can be relieved, however, when fathers take an active role in parenting. This allows father-child bonds to be created and it frees mothers to give more attention to the fathers and the marriage relationship.

Parents have a right to happiness and satisfaction in their parental roles and relationships. They have a right to happy, healthy, children who in turn have a right to happy, healthy parents and a secure home. To ensure this, prenatal and postnatal attention is required—both for children and for their parents.

No one would equate raising a child with raising a lawn. Yet even raising a lawn requires planning, time, and attention to nurture and insure proper growth. Should we be prepared for less with our children? We have all heard about "the ounce of prevention." It is worth more than a pound of cure.

UNDERSTANDING THE JANUARY BLUES

Songs, greeting cards, and friends remind us to be merry and happy during the holidays. Did you find yourself sometimes feeling just the opposite during the holiday season? Well, stop worrying about it, for that can be a typical reaction. Why would we be blue at the happiest time of year?

Let's look at what happened during the holidays. Many families had a reunion. Several generations got together under adverse conditions. Some traveled great distances after working until the last minute and were tired and irritable when they arrived. People were not accustomed to being with so many human beings and pets at the same time.

Routines were disrupted. Adults used to getting up and having breakfast at 6:30 a.m. discovered that the coffee wasn't ready until 9 a.m. Different noises and strange beds caused sleepless nights for both children and adults.

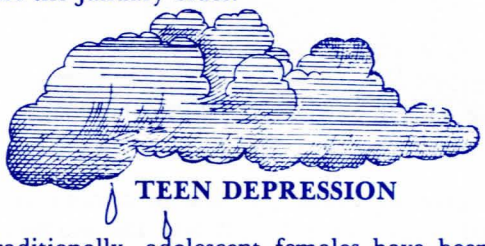
It has been said that absence makes the heart grow fonder. Family members ordinarily friendly through correspondence were suddenly confronted with jealousy, anger, and other unhappy feelings when face to face. Emotions long hidden, but unresolved, surfaced under the pressures of holiday tension. As grandparents get older, the grown children may unconsciously compete for power and control of their parents' attention, time, money, or life. This battle, whether fought in the open or covertly, causes confusion and conflict which may lead to depression on the part of those involved.

Maybe your family didn't have a reunion, which might have made you sad and lonely. People separated geographically or emotionally from family or dear friends at the holiday season may grieve the loss of close ties.

Another reason for January blues may have been greeting cards and gift giving. With the spiraling costs of cards, postage, and presents, many of us had to give up traditions of holiday sharing. We feel bad about receiving from others when we had not given in return. The opposite may be true, too. We may feel angry about sacrificing time and money to remember some of our friends and relatives who didn't seem to feel as warmly toward us.

A few people who got cheated out of their own childhood, or else never outgrew it, took advantage of the holiday season to act immature. They got drunk, or stole, and carried out some other unacceptable behavior. Sometimes childishness took simpler forms. Daughters pouted in jealousy, husbands went off their strict diets and got sick, and older folks demanded undue attention. Maybe you were the victim of a drunk driving accident, theft, or you felt torn when relatives asked too much of your time and energy.

What can you do about it all now? How can you better handle the January blues?



Traditionally, adolescent females have been less involved in the mental health and juvenile justice systems. However, this has changed in recent years as both female delinquency and suicide have increased in the 12 to 18 year age group.

On the surface, these trends seem to represent opposite forces in motion, i.e., delinquency as an active-angry response and suicide as a passive-resigned response to adolescent problems. In fact, they are seen as two sides of the same coin and represent unsuccessful attempts of adolescents to cope with emerging depression. Many observers feel that both of these responses are increasing among teenage girls because of several converging social forces.

First, over the last 20 - 25 years parents have tended to be more permissive and less discriminatory between girls and boys in restrictions on their activities and autonomy. This has resulted in more social freedom for girls.

Second, changing attitudes toward drugs and premarital sex have increased pressures on girls to become socially mature and sexually active earlier. This has resulted in higher rates of substance abuse and unwed teenage pregnancies.

Third, the women's liberation movement has undoubtedly affected the self-perceptions and behaviors of adolescent girls, but this cannot be easily measured since it may have a differing impact on subgroups among adolescent females. (On the one hand, this movement may have increased women's options and opportunities, while on the other hand, it may have also increased their anxieties about their feminity, their sexuality, and their ability to compete with men without sacrificing their sterotypically positive "female traits.")

Delinquency may be one way an adolescent female can assert her equality with males and direct her aggression against society, At the same time she can ward off her depression over how to deal with her emerging sexual and social freedom. This idea is partially supported by the fact that female delinquent offenses have increased in violence in the past decade and they tend to occur more frequently in the presence of male companions.

On the other hand, suicidal behavior may be chosen by those teenage girls who feel helpless about parental and/or peer relationships or are unable to develop a more constructive or acceptable way of dealing with self-perceived social or sexual pressures. They eventually direct their destructive impulses on themselves.

Adolescent males are more likely to be involved in fatal accidents and violent suicides than females. This suggests that sexual differences may affect the choice of solving depression. However, the issue of sex differences in the handling of depression, as well as issues of ethnic or sociocultural differences, need to be clarified by more research.

Like depression, suicide among adolescents seems to be on the rise. Between 1960 and 1980, the suicide rate among 15 - 19-year-olds increased by 136 percent. Among boys, who commit three-fourths of the suicides, the suicide rate soared to 154 percent. Suicide attempts, three-fourths of which were made by girls, are estimated at 100 to 150 times more common than actual suicides. And although most psychiatrists now believe that the majority of people who attempt suicide do not mean to succeed, as many as 20 percent of those who make an attempt later complete the act.

The best lead so far in predicting which young people are at high risk for ending their lives is a low level of the neurotransmitter serotonin. Yet many girls with low serotonin levels don't try to commit suicide. They tend to develop bulimia instead.

Of all the behavioral problems that strike during adolescence, bulimia is perhaps the most bizarre. The disease is characterized by an uncontrollable urge to binge—as many as 100 calories a minute or 5,000 calories per 30- to 60-minute binge-up to five times a day—and then purge by vomiting or taking laxatives. Like suicide, bulimia is on the rise, and recent studies suggest that as many as 15 percent of adolescent girls may have the disorder. While between 70 and 80 percent of these young women maintain their normal weight and thus are difficult to spot, the remainder lose so much weight they become dangerously malnourished. Between 50 and 70 percent of bulimics have a major affective disorder, and there is a strong link with depression that runs in families.

There is a future critical need for three major developments in the area of adolescent depression: research, preventive programs, and treatment services.

Most of the previous research has been done with disturbed or delinquent adolescents, so little is known about the incidence and the natural history of depression in normal adolescents. Research on adult depression has shown that there are ethnic and sociocultural differences in the incidence of depression, its symptoms, and its behavior. These same issues need to be looked at in adolescents to develop baseline data for planning programs and treatment services.

A second major need is prevention programs and early intervention of adolescent depression. For example, counselors and teachers in junior high and high schools should be aware of the early warning signals of teenage depression. These include an abrupt change in academic performance, social isolation, anti-social behavior, or substance abuse. Schools can set up peer counseling pro-

grams where adolescents can share their concerns and problems in a mutually supportive and non-judgmental atmosphere.

Suicide prevention programs and drug abuse "hot lines" should be aimed at adolescents through school and community programs. Sex education and family planning services should also be available to all teenagers. All of these programs should be adequately funded, operate confidentially, and use counselors who are well-trained in recognizing signs of depression and in making appropriate referrals for treatment.

The challenge of the 90's will be to provide adequate outpatient services and residential treatment facilities for those adolescents who need professional help for their emotional problems. Without such services, society will fail in its obligation to the mental health of tomorrow's adults. If, through research and observation, we can learn enough about the genetics, the biochemistry, and the social factors that combine to produce behavioral problems in kids, we can help reduce depression and make life better for them now and in the future.

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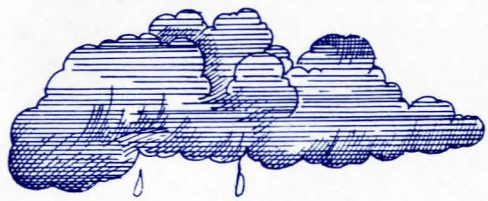

LIFE EVENTS

The term "life event," refers to a change in a person's social circumstance that causes a disruption in the customary pattern of living and requires adaptation. Some clinicians define this change in a life event as STRESS.

A life event can be desirable (a job promotion) or undesirable (the death of a loved one or the loss of a job or a home. It can also be defined in other ways: whether or not it can be controlled by the individual: whether it is an "entrance" type of event (such as the birth of baby), or an "exit" (such as a divorce); anticipated or unanticipated; major or minor; involving other people or only oneself; short term or long term; recent (occurring within the last 6 to 12 months) or remote (such as the death of or separation from a parent in childhood). Life events can be roughly broken down into health, work, home and family, personal and social, and financial.

Researchers have found that certain kinds or clusters of life events can cause or trigger clinical depressions. Studies have shown more "exit" events (such as the loss of a significant person through death or separation), more undesirable events, more "severely threatening" events, and more uncontrollable events in the 6 months before to the onset of clinical depression than in nondepressed control groups or in groups with other psychiatric disturbances.

One researcher, studying the relationship of life events to depression in women, identified four "vulnerability factors" that appeared to increase the likelihood of a depressive episode in the face of a stressful life event or events. These were:

- unemployment
- three or more children under the age of 14 at home
- lack of a confiding relationship with a partner
- childhood loss of a parent through death or separation.

All four of these factors are presumed to contribute to depression by rendering an individual less able to cope with stress. Research studies based on this model have not supported it as a whole, although in some investigations certain aspects of it, such as the lack of a close confidant among women (but not men) have been associated with depression. It is still not clear, however, whether specific "vulnerability factors" cause depression or merely interact with it.

Depression itself may also cause stressful life events to occur. For example, a woman may become depressed following a divorce. She is irritable and begins to isolate herself. At first her friends rally around her, but as months go by, her behavior alienates many of them. Her lack of sleep and inability to concentrate interfere with her work; she is eventually fired from her job. When she emerges from the depression, perhaps a year later, she has lost not only her husband, but also her job and many of her friends. Negative life events are not always connected to depression: some depressions develop without an apparent precipitating event, while other events are enured without being followed by any kind of depressive episode.

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