

BC's
Mental
Health
Journal

Visions



Mood Disorders



“Seamless Armour” by Bill Pope (full-colour original)

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Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers, and community. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association invites readers' comments and concerns regarding articles and opinions expressed in this journal. Please e-mail us at office@cmha-bc.org or send your letter with your contact information to:

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the Canadian Mental Health Association, BC Division or its branch offices.

The good news is that mood disorders such as depression and manic depression are finally coming out of the closet. Prominent people such as Margot Kidder and Michael Wilson are sharing their experiences with these conditions. As a society, it's becoming easier to acknowledge the illnesses' presence in our midst. Going hand in hand with this increasing openness is a growing array of treatment alternatives that make a difference.

At the same time, we're becoming more aware of the interconnections between mood disorders and issues of physical health, such as lifestyle, and with health conditions like heart disease and diabetes. This emerging knowledge will undoubtedly help us improve the prospects for dealing with both physical and "mental" disorders as we recognize how each side of the "mental/physical" coin can positively

affect the other.

While we move forward on these fronts, however, new challenges are presenting themselves elsewhere. Mood disorders are becoming more common in our young people and in the developing world. The incidence of suicide — which is often triggered by serious depression — is becoming a grave problem in the elderly and is referred to as "reaching epidemic levels" in Aboriginal peoples. Some of the alternatives that are known to work, such as an approach known as "cognitive behavioural therapy," are not readily available to the general public. Many of the social influences on depression (abuse, stress, and poverty, to name a few) are enormous, growing problems that require a concerted societal effort over time.

In this issue of *Visions* we'll hear first-hand about the experiences of people who have struggled with and gained control over

mood disorders. We'll look at some of the things that influence the development and course of these illnesses, focusing on the role of lifestyle and health factors. We'll also consider the range of approaches that have shown success in helping people get back on their feet. Finally, we'll take a look at the relationship between mood disorders, work, and creativity. It is impossible for us to address the full range of issues connected to mood disorders. We do hope, however, that the reader gains new insights into some of the facets of these conditions.

As is usual in this journal, we also hope that the edition not only spreads understanding, but acts as a practical resource for people who live with mental illness and all those who care for them. As always, we look forward to hearing your response.

Eric Macnaughton

- Special thanks to Bill Pope whose painting *Seamless Armour* was selected for our cover. Bill is a mental health consumer who lives in the Vancouver area. Bill's artwork is also featured on pages 37 and 41 and he has written an article as well (see page 40).
- More artwork for this issue of *Visions* has been generously donated by Desneige McLean (see pages 12, 15, 27, 33, and 35). Desneige is a fourth year Visual Arts student at Simon Fraser University. Her brother lives with a mental illness.
- Thank you to Ken Hansen for his contribution of poetry (pages 35 and 42). Ken is a consumer from BC's Sunshine Coast.
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Managing Mood Disorders

Robert Winram

While I was on vacation in a church far in the south of sunny Spain, I watched a man washing his hands with invisible water. Over and over he washed almost to his elbows, interrupting the washing only to make quick touches to his head. It seemed that he was praying for relief from his obsessive-compulsive behaviour — a form of anxiety that can accompany a mood disorder. What suffering! Non-stop he washed, and I rededicated myself to spreading the news that there are solutions for mood disorders.

Managing mood disorders has many components, and there are a variety of strategies that people use to discover and maintain good health. In this edition of *Visions*, several points of view, treatment styles, or roads to recovery are offered for your consideration. In Spanish, there is a word, *polyfácético*, which means ‘many faces.’ As there are many types of depression and manic depression that can creep up on us, there are many faces or facets of treatment and lifestyles that must also be attended to if we are to successfully manage these conditions.

We now have medications that are effective for most people. These usually provide the starting point of recovery. However, there are lifestyle issues that contribute very heavily to successful outcomes. As I was not given a diagnosis for more than 25 years, I had no understanding of the ways my lifestyle was aggravating my manic depression. For instance, I



Robert Winram is the Executive Director of the Mood Disorders Association of British Columbia (MDA); he also lives with a mood disorder himself. The Association has been around almost twenty years and has support groups all over BC for people with mood and anxiety disorders and their friends and families.

didn't realize that my love of sugar, soft drinks, and a particularly irregular diet had an effect on my mood. Substance abuse is often an issue, as people try to self-medicate, possibly drinking to get to sleep. Not being able to stop smoking, I stayed away from alcohol and drugs, as I felt I had such little control of my life as it was.

Even something as positive as exercise can, in illness, be overdone. When I was building into mania, my exercise was so intense, so rushed that rather than bringing balance to my life, it fueled the mania. Then, in depression, when just getting out of bed was the problem, the thought of regular exercise seemed impossible.

Rebuilding social networks after manic or depressive episodes takes time. In mania, I sometimes said things that could not be called back. During a depression, I would go months not answering the phone, resulting in unpleasant isolation. It took months after each manic or depressive episode to mend my broken social networks.

It's not appreciated how much damage is done to a person's confidence by an episode of mania or depression. It is so

debilitating and frightening when the mind ceases to work well. For some, this results in an inexplicable, generalized anxiety while others, in the same situation, develop anger. In a state of anger, it is very difficult indeed to recover one's health. When people have overcome their anxiety or anger to the point that they want to contribute to society or those around them, then they truly are back on track.

The most important part of my recovery was to develop insight. I learned about the illness, its patterns, and built support networks with friends and family. Eventually, I could “see” the mood swings and the early signs. Then I would contact my doctor and intervene before I was dealing with a full manic or depressive episode. It takes trust to work with others and give them permission to give you their input. The self-help model used by the Mood Disorders Association of BC (MDA) helped me learn from others what my early signs might be. The sincerity of those at the support group meetings helped substantially increase my trust, as I realized I wasn't the only one living with the challenges of a mood disorder.

MDA was started 18 years ago by Ed and Vicki Rogers. Ed had developed manic depression following surgery. The illness came on so suddenly, he was particularly interested in learning more about it. He attended a meeting at the Canadian Mental Health Association (CMHA) where he met people who were also dealing with mood disorders. He brought them together for the first MDA meeting in the basement of his home. From that first meeting, MDA has now grown to almost 50 support groups around the province (for information, call (604) 873-0103 or visit www.lynx.net/~mda).

These illnesses are now better understood, and we have improved medications. Even the arrival of the internet helps, as so much information can be quickly located on mental health issues. One site that is of particular interest is www.mentalhealth.com (see page 20). You can also check out the links section of CMHA BC Division's web site at www.cmha-bc.org.

As the science behind recovery progresses, we still continue to be burdened with the stigma of mental illness that keeps so many from realizing that there are solutions. Mental illness has alarming symptoms that we cannot pretend to ignore, especially now that successful management is such a reality.

We who have experienced good care and enjoy improved health need to end the silence by talking about our recovery openly and loudly — loud enough that the message will be heard even in a small church in the south of Spain. ■



Recognizing the Faces of Major Depression

Raymond W. Lam, MD, FRCPC

Dr. Lam is a Professor in the Department of Psychiatry at the University of British Columbia (UBC) and is Medical Director of the Mood and Anxiety Disorders Program at UBC Hospital in Vancouver.

Sarah is a 23-year-old homemaker who feels she can't cope because she is so tired and fatigued. Roger is a 48-year-old truck driver who feels bored with life. Alice is a 41-year-old lawyer who cries and feels suicidal. Maria is a 72-year-old potter with insomnia and disabling headaches.¹ What do all these people have in common? They are all suffering from clinical depression, a medical condition that is often unrecognized and untreated.

Clinical depression, known as major depressive disorder or major depression in medical terms, is the most common mental disorder and one of the most common medical illnesses in the general population. Major depression affects 1 in 7 people at some time in their life. At this moment, 1 in 25 people (4%), or 16,000 people in British Columbia alone, suffer from clinical depression. The chances of having depression are twice as high for women as compared to men. A depressive episode can last from weeks to months (and sometimes, years). The direct medical costs of treating depression in Canada exceed one billion dollars a year.

The social and physical costs of clinical depression are significant. A large study sponsored by the World Bank and the World Health Organization ranked the global burden of all medical diseases according to the combined mortality and disability caused by the disease. In 1990, major depression ranked fourth worldwide in combined disability, outranking heart disease, stroke, and AIDS. In fact, the only conditions that outranked depression were those experienced mainly by

Third World countries including infections, diarrhoeal diseases, and perinatal (i.e., before and after childbirth) mortality. This study also estimated that depression will rank second worldwide by the year 2020.

The most serious consequences of depression include death by suicide. One person commits suicide in British Columbia each day, and most people who are suicidal are clinically depressed.

Clinical depression can also worsen the outcome of medical conditions. For example, your risk of dying after a heart attack is four times greater if you are clinically depressed. Depression is a greater risk factor for predicting death after heart attack than a history of smoking, previous heart attacks, and poor heart function. (also see page 31).

Symptoms of Depression

Unfortunately, major depression is often unrecognized and untreated even when people are seeing health professionals.

In part, this is because many patients present physical symptoms and the depression is missed. Table 1 shows the symptoms experienced by people with major depression. Many people are like Alice in that they feel sad and blue and cry during a depression. Others, like Roger, may not notice depressed mood but will experience lack of interest in usually pleasurable activities. Most patients have physical symptoms like changes in sleep, appetite, and weight. Maria has insomnia and wakens early in the morning, unable to sleep. She also has no appetite and has lost 15 pounds over the past few months. Sarah, however, experiences oversleeping and

Table 1: Symptoms of Major Depressive Disorder

<ul style="list-style-type: none"> ■ DIAGNOSTIC SYMPTOMS <ul style="list-style-type: none"> <input type="checkbox"/> Depressed mood <input type="checkbox"/> Loss of interest <input type="checkbox"/> Sleep problems (insomnia or oversleeping) <input type="checkbox"/> Appetite problems (loss of appetite or overeating) <input type="checkbox"/> Feelings of guilt <input type="checkbox"/> Low energy <input type="checkbox"/> Poor concentration <input type="checkbox"/> Psychomotor disturbance (feeling slowed down or agitated) <input type="checkbox"/> Thoughts about suicide ■ ASSOCIATED SYMPTOMS (symptoms which may accompany depression) <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Low self-confidence and self-esteem <input type="checkbox"/> Cognitive distortions (negativity, pessimism) <input type="checkbox"/> Dependent behaviour <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Sensitivity to criticism <input type="checkbox"/> Irritability

overeating during her depression along with carbohydrate cravings and weight gain. Some patients feel physically and mentally slowed down, while others feel agitated.

Feelings of hopelessness, helplessness, and worthlessness are also common when people are depressed. They often think of death and may have thoughts about suicide. There are many myths about suicide that flow through our culture and are still held by some health professionals. One myth is that asking about suicide makes it worse. This is not true. Most people, like Alice, are relieved when they are asked about suicidal thinking and find out that it is a common depressive symptom that can be treated.

Many associated symptoms are found in major depression but are not part of the formal diagnostic criteria. Roger experiences anxiety and has cognitive distortions where his thinking becomes very negative and pessimistic, as if he is seeing



▼ "Faces of Depression" (NMHA 1993 video cover)



the world through a depressive filter. Alice became indecisive in her court work, and her self-confidence and self-esteem fell. In severe cases, patients may be psychotic, losing touch with reality. They may have hallucinations (perceptual disturbances such as seeing things or hearing voices) or delusions (false fixed beliefs such as feeling responsible for wars going on in the world). Maria was very distressed because she heard voices telling her that she was evil and that she deserved to die.

Diagnosis of Depression

With all these different types of symptoms, it is not surprising that clinical depression is sometimes difficult to recognize. Screening questionnaires such as the Beck Depression Inventory can be helpful. This widely used, self-rated, 21-item scale helps to identify people who may be depressed, but by itself cannot be used to diagnose a clinical depression. Research has shown, however, that two simple questions can be as sensitive as a screening questionnaire: “Have you been feeling sad or depressed?” and “Have you lost interest in your usual activities?” By regularly asking these two questions, many clinicians will be able to identify patients with a clinical depression who might ordinarily be missed.

To make a medical diagnosis of major depression, at least 5 of the 9 major symptoms must be present for at least two weeks. These symptoms must also cause significant distress and/or result in impairment in functioning at work or with relationships. Other medical conditions that can have depressive symptoms (Table 2), prescription medications, and alcohol or substance abuse must be ruled out before making the diagnosis. The normal process of bereavement is also excluded, although extended periods of grief may turn into something meeting the criteria for a major depressive episode.

We classify people with a depressive disorder separately from those with bipolar disorder (formerly called manic-depressive illness). People with bipolar disorder experience manic episodes at some time in their lives in addition to having depressive episodes. During a manic episode, people with this disorder are uncharacteristically euphoric (or irritable), hyperactive, grandiose, and distractible. They speak very rapidly, have racing thoughts, and have less need for sleep. In severe cases, they will also experience psychotic symptoms, sometimes believing they have special powers like telepathy. During the manic episode, they have poor judgment and show

impulsive, reckless behaviour such as spending money or getting into needless arguments.

We also differentiate subtypes of depression, including patients with “psychotic” depression (with hallucinations or delusions), “atypical” depression (with overeating, oversleeping, and mood reactivity), and “seasonal” depression (with depressive episodes only in the winter). Distinguishing bipolar disorder and these depressive subtypes is important because they have specific and different treatments.

Causes of Depression

The causes of clinical depression are not known, but it is clear that there is a complex interaction between psychological and neurobiological factors. Genetics play a role as clinical depression can run in families, and the chance of having a clinical depression is increased if a family member also has the condition. However, it is not yet possible to predict who in the family will develop depression. Many studies show biological changes in the brains of people with clinical depression, especially in neurotransmitters, the chemicals involved in transmitting signals between neurons. Disturbances are found with serotonin, noradrenaline, and dopamine, the main neurotransmitters regulating mood and emotion. There are also many hormonal abnormalities and disturbances in the biological function of sleep and circadian rhythms (the daily rhythms generated by the biological clock in the brain).

There is also much evidence that psychosocial factors are important. Early parental loss, social isolation, personality style, and stressful life events can all increase the risk of developing a clinical depression. For example, Roger began to be depressed after a recent separation from his wife, while Sarah is struggling with marital and parenting stress.

Unfortunately, for an individual person, it is not usually possible to identify a single cause of depression. However, it is still important to identify biological, psychological, and social factors that may be contributing to the clinical depression because specific treatments can be targeted in each of those domains. For example, antidepressants can be used for biological factors, psychotherapeutic approaches can be used for psychological factors, and occupational or marital therapy can address social factors. Later on in the issue, we’ll return to the stories of Sarah, Roger, and Maria, and look at the treatment alternatives that they’ve found helpful. (see page 16) ■

Footnote

1 All names and case histories are fictitious and represent an amalgamation of patient stories.

Table 2: Some Medical Conditions with Depressive Symptoms

<ul style="list-style-type: none"> ■ NEUROLOGICAL <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer’s disease / other dementias <input type="checkbox"/> Huntington’s disease <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson’s disease <input type="checkbox"/> Stroke 	<ul style="list-style-type: none"> ■ CANCERS <ul style="list-style-type: none"> <input type="checkbox"/> Brain <input type="checkbox"/> Pancreas ■ INFLAMMATORY <ul style="list-style-type: none"> <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Systemic Lupus Erythematosus 	<ul style="list-style-type: none"> ■ CARDIOVASCULAR <ul style="list-style-type: none"> <input type="checkbox"/> Heart failure <input type="checkbox"/> Myocardial infarction (heart attack) ■ METABOLIC AND ENDOCRINE <ul style="list-style-type: none"> <input type="checkbox"/> B₁₂ or iron deficiency <input type="checkbox"/> Cushing’s Syndrome <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypocalcemia 	<ul style="list-style-type: none"> <input type="checkbox"/> Hypo/Hyperthyroidism <input type="checkbox"/> Uremia ■ OTHER <ul style="list-style-type: none"> <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Chronic pain <input type="checkbox"/> Fibromyalgia
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When it Rains, it Pours: The Co-Occurrence of Depression and Other Mental Illnesses

Carlene Daniel

Carlene is the Coordinator of the Open Mind Media Watch program at CMHA BC Division. She is going into her third year at Simon Fraser University, studying psychology and communications.

The importance of co-occurring mental illnesses has sparked the interest of many researchers, given the discovery that the majority (79%) of people who suffer from a mental disorder at some point in their life are diagnosed with more than one mental illness. Depression is no exception, as it is often diagnosed along with other disorders. While we don't know conclusively at this point why these disorders occur together, it is clear that the presence of co-occurring disorders increases the complexity of a person's treatment and the potential severity of their mental health condition. Below, we'll look at some disorders that may occur with depression: dementia, schizophrenia, anxiety disorders, and eating disorders.

Depression and Dementia

Dementia is a category of disorders characterized by the development of several cognitive deficiencies which impair a person's social or occupational functioning. Examples include memory impairment, deterioration of language, and impaired ability to carry out everyday activities like combing one's hair. The most common cause of dementia in Canada is Alzheimer's disease, which accounts for about 60% of cases.

Research illustrates the difficulty in separating the symptoms of dementia from the symptoms of depression

as they seem to be closely related. Depressive symptoms such as lack of energy, loss of interest, and disturbance in mind-body coordination are common in both depression and certain kinds of dementia. A study done in 1998 by the Stockholm Gerontology Research Centre found that a mood disorder (e.g., dysthymia, bipolar disorder) was diagnosed in nearly 12% of the participants with dementia. The study concluded that the prevalence of major depression is higher in people with dementia than in those without. In many cases, the presence of depression significantly affects the development of dementia, especially when dementia begins at an early age.

Depression and Schizophrenia

Schizophrenia is a mental illness which can be recognized by a mixture of symptoms including cognitive and emotional distortions that infringe on a person's ability to communicate, pay attention, and produce coherent thoughts and speech. Depression is now being recognized as a common feature of schizophrenia. Recent studies have shown that a substantial rate of depression (40-50%) has consistently been found in people with schizophrenia. Depressive symptoms are so similar to some negative symptoms of schizophrenia that they can be difficult to distinguish. Symptoms of both disorders include withdrawal, lethargy, emotional numbness, and

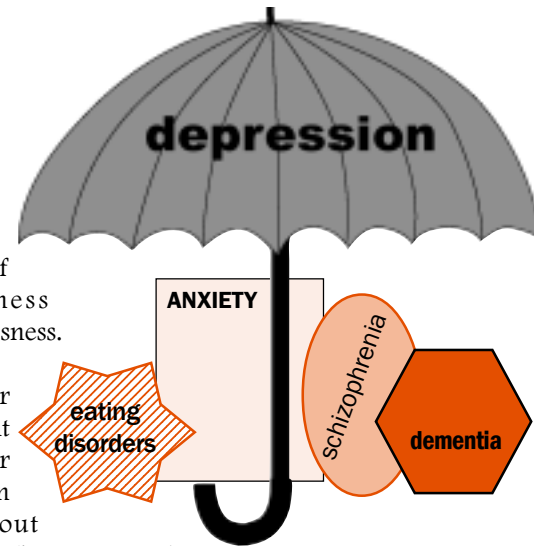
feelings of hopelessness and helplessness.

It is unclear at this point whether depression comes about secondarily (i.e., as a result of developing schizophrenia), or whether depression is an integral part of the schizophrenic illness. It is clear, however, that depression in schizophrenia must be recognized, particularly in the early phases of the illness, as the combination of these two illnesses puts the person at a much greater risk of suicide during the first years of developing schizophrenia. To deal with this problem, researchers at the Clarke Institute of Psychiatry are developing a form of cognitive behavioural therapy (CBT) to deal with depression in people who have been newly diagnosed with schizophrenia (see 'Related Resources' on opposite page).

The following quote, from a person who lives with both depression and schizophrenia, illustrates the need to deal with both issues: "The medication cleared my psychosis but it didn't do anything for the depression...I asked to go on Prozac even though they told me I didn't need anything, and when I [finally] did I felt like a totally different person."

Depression and Anxiety

Anxiety disorders include



panic disorder, obsessive-compulsive disorder, phobias, post-traumatic stress disorder, and generalized anxiety disorder. Each of these disorders has specific characteristics ranging from fears of public places or repetitive checking behaviours, to spontaneous overwhelming panic attacks. Although they are all different from one another, anxiety disorders tend to trigger reactions that are out of proportion to the actual situation.

Major depression appears to have an integral relationship with anxiety disorders. Over 30% of people who suffer from clinical depression have also had at least one episode of an anxiety disorder in their lifetime. The most common depressive symptoms that are experienced when suffering from an anxiety disorder are fatigue, insomnia, and concentration difficulties. Researchers are currently debating how and why anxiety and depression are related. Some people view major depression as secondary to anxiety, or something that happens as a result of having particular anxiety disorders. It may also be that anxiety occurs as a symptom of depression.



Although the causal relationship between depression and anxiety has not been confirmed, it is clear that when they occur together, consumers experience more severe symptoms and may have to work harder and take a different approach towards recovery. One person who has experienced with both illnesses describes her experience of recovery: “For me, it seems the anxiety and depression were quite separate. I had anxiety (but no depression) from a young age right into my teens ... and then the depression hit. The depression was so severe that it ended up giving me amazing perspective. I went from caring about petty little things in my anxious states to just being concerned about making it through the day. Going through depression actually ended up being the best cure for my anxious tendencies.”

Depression and Eating Disorders

Anorexia nervosa and bulimia nervosa are two of the most prominent eating disorders in Western society. Anorexia nervosa is characterized by excessive over-exercising and an immense fear of gaining weight. Bulimia nervosa is characterized by habits of binge eating followed by purging or other methods to prevent weight gain. The connection between depression and eating disorders is becoming increasingly evident.

Depression has been shown to be a contributor to the development of an eating disorder, as depressive symptoms influence a person’s feelings of self-worth. Low self-worth (especially poor body image), in turn, is one of the main risk factors for binge eating, purging, and

excessive exercise. From another angle, the effects from a serious eating disorder, such as malnutrition or excessive fatigue, can intensify the severity of depressive symptoms. Some scientists believe that the relationship between the two disorders may be due to common genetic factors that influence the risk of suffering from both depression and anorexia.

As noted above, when other disorders occur along with depression, it tends to increase the severity of a person’s mental health condition, compared to one disorder occurring alone. By recognizing this co-occurrence, however, we can better understand the nature of an individual’s disability and are in a better position to help the person make a full recovery. ■

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Levy, A.B. et al. (1989). “How are depression and bulimia related?” *American Journal of Psychiatry*, 146(2): 162-9.

A full list of references consulted is available upon request.

Related Resources

Depression and Anxiety. A cyber-journal more for the clinically-minded, but a useful resource nonetheless. Most of the volumes are accessible online at www3.interscience.wiley.com/cgi-bin/jtoc?ID=38924

“Treating Depression in Schizophrenia.” A description of a program being developed at the Centre for Addiction and Mental Health using cognitive behavioural therapy for people in the early stages of schizophrenia or a psychotic illness. www.camh.net/CLARKEPages/schizophrenia/depression_in_schizophrenia.html

Different Kinds of Depression

normal but potential (“depressive reaction” or “exogenous”)	<p>Normal Depressed Mood and Grief Depression can be a natural reaction to losses in life. What makes these reactions normal is that people eventually recover on their own — even after the death of a loved one. <i>If symptoms persist</i>, a person could have a clinical depression and should call a doctor.</p> <p>Adjustment Disorder with Depressed Mood Life is full of changes; coping with them can be difficult. Many people feel overwhelmed until they can get things under control. If they can’t or don’t, they instead become persistently gloomy, angry, and unable to cope. If these symptoms occur without a life change or they are out of proportion to the change, then call a doctor.</p>
clinical depressions (usually “endogenous”)	<p>Chronic Mild Depression (known as dysthymia) Just like it sounds, dysthymia is a low-level depression that always seems to be there. It may or may not have a triggering life event.</p> <p>Major Depression Again, like it sounds, when someone says they are “seriously depressed,” this is what they mean. You can suffer a major depression and not feel blue. Very often, major depression strikes without any triggering loss; 15% of people with major depression attempt or commit suicide.</p> <p>“Double” Depression Dysthymia coupled with a major depressive episode.</p> <p>Bipolar Disorder (Manic Depression) This illness involves major depressive episodes alternating with high-energy periods of manic activity, which are often characterized by risky behaviour, irritability, rapid speech and thought, and “delusions of grandeur,” e.g., feelings that one has special powers or can accomplish amazing feats.</p>
time-specific clinical depressions	<p>Seasonal Affective Disorder (SAD) Often called “winter blues,” SAD is a real psychophysical reaction to a lack of sunlight in winter. It is a mild or major depression that develops in late fall and clears up in early spring.</p> <p>Post-partum Depression This kind of depression occurs in the weeks or months after giving birth to a child. Due to hormonal fluctuations as well as the new challenges of dealing with a baby, about two-thirds of women feel a transient sadness; 10-15% become clinically depressed.</p>



Living with Depression

Dena Lea

Because of the nature of depression, it took me years to get into treatment. I found it hard to accept that I needed help, let alone find out where to go to get that help. Once I finally got started, it was very difficult to find the energy to continue. With depression, there are times when I'd be too exhausted to do anything, let alone go out and confront the world. But the good news is, with the help of a few key people, I am beginning to recover from the illness that has haunted so much of my life. Now that I have accepted my depression as a treatable illness, I *know* there is something I can do about it — and I don't have to do it alone.

Imagine what it would feel like to wake up in the morning wondering “what’s the point of getting out of bed?” Imagine that this is a daily occurrence, and no matter how much you have to do, or how bright and aware you know you should be,

“
Have you ever tried putting on a happy face when you weren't actually feeling bright and cheery?
”

you just can't shake the feeling. This is what depression does to you: it robs you of your interest, your drive, your joy, and your ability to do anything to help yourself.

Think about what it would be like to spend most of your time alone because being around other people is just too difficult. Of course, you know there are people who care about you, but when you're depressed, you can feel they are judging you. You're tired of being called names or told to “get over it,” and you've even become afraid to expose those you care about to the gloom and doom that seems to surround you. You may even fear that they, too, will tire of being around your dismal mood and shun you like so many have before.

Have you ever tried putting on a happy face when you weren't actually feeling bright and cheery? For a person with depression, it's extremely difficult to pretend that everything is “normal”; it's obvious to you that it's a façade, and it isn't working. You end

up feeling worse about yourself for having pretended.

Now try to imagine having all these feelings and not understanding that they are symptoms of a treatable illness. You don't realize it's not your fault and even believe you've “tried everything” and failed. From the inside of depression, you chastise yourself for not being a better, stronger person.

As a person who experiences clinical depression, I know these feelings from the inside out. Despite the fact that I know I am

an intelligent individual, I often feel these qualities are masked by a sort of melancholia that has a mind of its own. I know intellectually that my life has value, but when I am depressed, there's a part of me that simply doesn't know how to believe it.

At this point, you may be wondering “why am I still reading this?” I don't blame you, it's a depressing topic — and a very serious one. Perhaps you have had similar experiences, or maybe you know someone who has described these feelings to you. In either case, it is important to realize that depression is not an inherent weakness or personality flaw, and that it can become a serious illness. People with depression cannot just “snap out of it.”

Most of us experience a period of depression at some point in our lives, but over time, the feelings fade and life resumes its normal course. For a person with clinical depression, these episodes may be frequent or continue for a long time. In my experience, the episodes were shorter, less severe and occurred less often when I was young. They became longer and more severe as I got older; eventually, my condition became “chronic.”

Of course, understanding my illness was only the beginning of my recovery. Now I have to deal with the outside world and uninformed attitudes about mental illness. I've met very few people outside the mental health community who think about depression in the same way as diabetes or heart disease, which are also treatable illnesses. This makes it difficult for those of us who experience mental illness to share our stories and discover that we are not alone.

I was fortunate enough to find my way to a local mental health agency, through which I have discovered a whole community of open-minded and knowledgeable people. This is where I now go to get encouragement and support, knowing that I won't be judged for needing help. My wish for the future would be for more people to see illnesses like depression as treatable medical conditions, so those of us living with mental illness can feel more supported as we move towards wellness. ■



Highs and Lows Choir
A choir for consumers and their friends and family



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(extension 211 or 201).



My Squeaky Wheel

I've decided that I must never procreate. For if I do, I'm convinced I'll very likely pass down the suffering for which I believe I was destined when I was conceived by my parents who raised me in a dysfunctional environment (although at least part of my mental illness was likely acquired genetically). And, thus, my misery will end with me.

Potential parents concerned about their future offspring's acquisition of mental illness, however, need not completely deny themselves procreation. Instead they can, and definitely should, educate themselves as extensively as possible — *before they have children* — about how to rear their offspring in a mentally functional environment. Although people planning to be parents cannot control the genetic traits which may be passed on to their children, new parents definitely can control the emotional surroundings of their children's family life and upbringing.

And be not mistaken: it is too easy to ever-so-slightly treat one's infant in a psychologically unhealthy manner without even realizing the fact and thus to leave the child susceptible to developing, for example, a dysfunctional thought process, which can remain with him or her for life. For example, if my parents knew what incredible suffering their allowance of my witness to their incessant worrying would do to me as a little boy and as an adult, they would very likely have altered their behaviour in my proximity.

These are compelling reasons

why mental health resources should place an emphasis on family environment as well as awareness and treatment.

Mental illness is like any other form of illness, yet "normal" people who have not been directly or indirectly affected too often tend to perceive it not as a real illness, but rather as something you can snap out of if your mind is adequately disciplined — for it involves the mind, and if your character is strong-willed enough, you should be able to will it away, right?

Even at a time when society has established Mental Health Week, it is still implicitly socially acceptable to stereotype people with mental illness as being more potentially violent than the average person, although the opposite is true. Furthermore, the opinions of people with mental illness are not taken as seriously as those of the "normal" population. Take, for instance, the media's on-and-off misuse of the word "schizophrenic," a term for a serious mental illness, to describe, for example, inconsistency in a politician's election policy. This usually reveals how much consideration the media has for the victims (including family members) of this illness.

Furthermore, many people with mental illness, although officially considered "disabled," are still perceived by some in the "normal" community as not really warranting social assistance; after all, they could be digging ditches, right? But speaking for myself, I always put in 110% effort when I'm doing my volunteer job (or any kind of job)

even though, according to prevalent societal thinking, since I do not earn a "regular" pay cheque for doing "regular" work, I am not actually working or really contributing to society.

But as long as the mentally-ill person's wheel fails to squeak, it will get no grease. The community must speak out to achieve change. Pension cheques, at best, will barely take into consideration inflation levels and hospital bed numbers will inadequately deal with those with serious mental illness who will instead be left to the mean streets, jail, or suicide. Our suffering is only worsened by the fact that mental illness cannot be measured in a physically tangible manner like skin cancer or AIDS, so that some of us are left to languish in a private, hell-like, internal torture chamber of the mind.

Although I do *think* about taking my own life, I do not actually *contemplate* (there is indeed a difference) such a drastic, selfish measure because of both fear of divine punishment and the intolerable fact that I, by my suicide, would leave behind my loved-ones to grieve.

But always remember, people with mental illness do not want to kill themselves; rather, they simply want their mental anguish to cease. Which is why often the only consolation that many suffering people have in life is their belief that each day they endure and survive will not have to be repeated — every day's end is one (albeit small) step closer to that permanent, blissful sleep and peace. ■

Frank G. Sterle, Jr.

poetry

NOT MINE

**candlelight vigil
for the me I have lost
for the me I've become
but don't wish to be**

**an alien force
inhabits my nervous
system
plucks my emotions
slowly
as if I'm being
defeathered
one
neuron at a time**

**an alien force
holds my gray
matter
as if it wanted to
break it apart —
just a head
of cauliflower**

**sometimes
I think it has succeeded
when I'm not
looking
because inquiring minds
want to know
why I am crying
"I wish I knew."**

these tears are not mine

**this grief is for me
for something which
has died
will be reborn
and will die again**

this grief is for me

but it is not mine

—S.

Consumer (Burnaby, BC)



Kelly's Story – A Journey Beyond Grief

Donna
Murphy

My greatest joy has been in raising my only son, Kelly. At the age of 16, Kelly sank into a depression, which ended with his suicide on April 3, 1997. In this article, I have an opportunity to tell my story, and trace the path of Kelly and my journey through life, my continued recovery, and how I have become focused on my life mission to make a difference to other children and their families through advocacy.

April 3, 1997. That was the day that my path in life changed forever. It was a sunny spring day, and I was running across the parking lot of my school when I was called back to take a call from the RCMP. As a teacher of behaviour and conduct-disordered children, I felt that it must surely involve one of my former students. I was told that there was an ongoing investigation and that I must stay at the school.

As I waited for the officer to arrive, I must admit that I was feeling unusually nervous. I wondered if my son, Kelly, was in trouble, but then again I thought no, it's one of my former students. Shortly after, the officer arrived at school and I escorted him into my principal's office. We sat down and he looked at me and said, "Donna, Kelly's dead." Then he told me that my handsome, intelligent, talented son had hanged himself that day in his bedroom and that I should go home from school. To this day, it is so unbelievable that the happy child I raised could fall into such a depression as an adolescent that he had no recourse for his pain but to opt out from this life. I will never forget the face of that officer or how at that moment, the ground seemed to fall out from under me, and I knew that things would never be the same again.

My boy — my only child, whom I loved more than anyone — gone, dead at the age of 18. I do not remember much else about the next days as I said my last goodbyes to Kelly. However, I do remember that my friends and family went into action as I went through the process of burying my boy. My clearest memory of that time is when my youngest brother was overcome with grief, a grief so deep that even in my sorrow, my heart went out to him. I took him in my arms and promised him that Kelly's death would not be in vain, that I would use my love to make a difference for other young people and their families in

need so that they would not have to go through what we had endured. To this end, I have kept my promise to my brother and Kelly.

It is fine to say that the world would be a better place because Kelly Murphy lived, but I did not even know where to begin. I started to visit the professionals who worked with him and listened. They told me what they believed in and what I could do to make a difference. One thing was very clear through it all. The place that Kelly hated the most was the adult psychiatric unit; I was told that if I could influence a change in this area, it would be a great tribute to Kelly. This was the impetus behind the work that I did towards the realization of the Adolescent Psychiatric Unit at Surrey Memorial Hospital (to open in 2001).

Another told me to teach, to help to enlighten people to childhood mental illness and to adolescent suicide, its prevalence in our society, and the great toll it takes on the lives of everyday people. I knew that both these issues were very important to children, and I knew that I could make a difference in these areas. I also knew that this would become my life mission: raising awareness of depression and suicide in children and youth and lobbying for education in the school system for suicide awareness so that children would learn the facts about suicide. They would learn that they have other options, that there are places to go for help when they are in the depths of despair.

I knew that my great love and respect for my son would lead me to help others and to make a difference. From the start I have believed that I would work towards one small change, and that when my job is done another will

come along and take up the slack. Advocacy is a job that can be learned through experience, however difficult that experience may be. Had I not followed my heart in this belief, I would have devalued Kelly's life.

What differences have I, an ordinary mom, made since Kelly's death? Variety Club became involved through the 1998 Show of Hearts when a vignette supporting adolescent mental health was developed, featuring Kelly and me. Through lobbying our school district, a suicide awareness program — SPEAC — Suicide Prevention Education, Awareness, and Counseling was developed; every grade nine student in Surrey now receives suicide awareness education. As well, my involvement in our



▼ photo artwork by Andree Faucher, consumer

People feeling depressed and hopeless enough to consider suicide often see "no exit" out of their current state. Below are some signs to watch out for.

Warning Signs of Suicide

- recent attempt or other form of self-harm
- talking or joking about suicide, what it would be like to die
- sudden risk-taking behaviour
- deliberate self-harm, e.g., cutting one's self
- expressing hopelessness about the future
- withdrawal from friends, family or activities
- abuse of drugs or alcohol
- uncharacteristic self-neglect (hygiene)
- hears voices instructing them to do something dangerous
- a history of suicidal gestures or attempts
- giving away treasured keepsakes
- questioning own value and worth

To help someone who is suicidal, see www.metanoia.org/suicide/whattodo.htm



Manic Depression: The Giver and Thief

I was asked to write something about my experience of mood disorders. All right, here it is: I hate my mood disorder, manic depression.

I picture this figure, Manic Depression, standing on a snow-swept street corner, his grin winsome and cruel, opening his jacket. The inner lining is decorated with his wares: locks of female hair, the usual stimulants, foreign language dictionaries, other beautifully bound books (usually of poetry), and many stolen wristwatches. “What

time is it?” he says and answers his own question: “Time to buy a watch.” His laughter is not attractive, and it lingers. He leaves, not bothering to say goodbye, for we both know he’ll be back.

I hate him because, in the guise of giving me rare and precious gifts, he has time and time again stolen from me. I have become aware of some of his tricks, the sneaky way he will insert himself into my thoughts and desires, the clever way he has of coming between me and other

people. He offers adventure, achievement, transcendence, and romance; he steals reason, security, real connection with others, and tolerance.

Worst of all, having done his damage he vanishes, leaving me to blame, but not without his shadow imprinting my soul. It is as if he has the power to transmigrate¹, and when I have suffered from his grip, reeling from the effects — the broken relationship, the lost job — I find myself on a street corner, lonely, frightened, needy, having to sell myself

all over again. Then I realize that I am he.

The watches glitter. They tick. What time is it? The time is forty, my life (statistically) more than half over. He kicks at some leaves, then turns to mock me.

Worse, other people seem to know him better than they know me, or they think that I am him, without grasping the complexity of the processes involved, how many entanglements and retreats, the steepness of the slopes, the

5bcbrn cng

Footnote

¹ the ability attributed to souls to move into another body

community has brought a heightened awareness of child and youth mental illness and suicide to every sector of society. My message is clear: “If this has happened to me, it could happen to you. If not to you through your children, then perhaps through a relative or the child of a friend.”

The day that Kelly died was the day that my heart broke forever. Up until that time, my road in life was so easy. The moment that the words were spoken — “Donna, Kelly’s dead” — the road crumbled beneath my feet. I could not veer off in another direction because there was no direction to go. So if I were to continue to go on living, I would have to build a new road for myself. To do this, I would have to rely upon the professionals, my family, friends, and my great love for Kelly. To go on, I would rely on the insights that Kelly had given me and other gifts that I had been given through him.

The professionals I came to rely on were his adolescent psychiatrist who offered me support in my quest, the people who worked at the Foundation Office at Surrey Memorial Hospital, and Kelly’s counselor, Maria. Sometimes in life you are sent special gifts. So it was with Maria. Although she had worked with Kelly, she was truly sent to lead me on my journey through grief and into recovery. It was through her that I learned to pick up the pieces of my life, to go on living and continue to work towards acceptance. It was through my partner, Ron, and through the great support of my family and friends that I have been able to come to the spot in my life where I am now, knowing that I am able to go on. I know that my life mission will not end until I die and that Kelly’s life will make a difference to others.

And so my journey beyond grief continues. People have said to

me that they are impressed by how my family talks about Kelly, as if his death had not been a suicide. We are not ashamed of what he did, although all of us wish he had not made that decision for himself. We miss him, and rejoice in his sense of humour, intelligence, and the funny things that he did while he was here with us. It was my greatest privilege to have had Kelly Murphy for my son — to have known him, to have loved him, and to be able to raise him. This is where I get my strength and focus.

Through advocacy, I will continue to fight for changes for families. I know that changes are coming and through lobbying and fighting for what we know is right, we will bring depression and mental illness in children out into the open. This is Kelly’s contribution to society. This is why he lived on earth for his short while, and why I continue to fight. My journey has just begun, and I don’t know where it will lead me, but I do know that it will be a journey that allows me to continue to heal and helps others along the way. ■

If you would like to get involved or support Donna’s formal advocacy efforts, you can reach her at (604) 596-9593.

Related Resources

For information about the Suicide Prevention Information and Resource Centre, to see *Youth Suicide: A Framework for BC*, and to see the newsletter *Lifenotes*, go to www.mheccu.ubc.ca

To see the draft suicide prevention strategy proposed by the US Surgeon General, go to www.surgeongeneral.gov/library/mentalhealth/

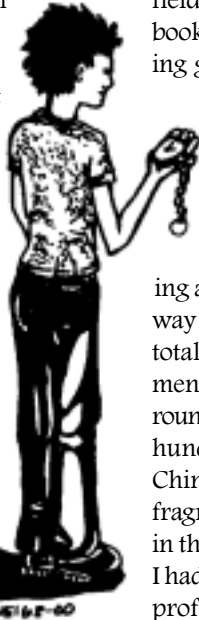
For more depression and suicide prevention information, consult the Australian Early Intervention Initiative at ausienet.flinders.edu.au

Night Falls Fast (Knopf, 1999) a book about suicide by Kay Redfield Jamison.



chilling damp of the declivities.

He had this effect on me because his wares, after all, were gorgeous and also seemed to match my talents: a skill with language, an enthusiasm for studying foreign languages, a romantic, idealistic



field Jamison speaks in her book *A Fine Madness* of being granted access, through manic depression, of corners of her heart and soul that were breathtaking, shocking her with their beauty. I know what she's talking about. Once, inching my way through an underpass in total darkness near Tiananmen Square in Beijing, surrounded and comforted by the hundreds and hundreds of Chinese voices, making out fragments of their meaning in their marvelous language, I had a grasp, instantly, of the profound unity of humankind. But one cannot live on metaphor for long.

nature, the usual attraction to the opposite sex. He perceived these qualities and traded me for them; I received an egotistic belief in what is after all only a modest literary gift, a deluded idea that I could penetrate and dissolve myself in other cultures without first understanding my own, and a habit of infatuation with women whose real needs had nothing to do with me.

It is not that he has given me nothing, though. Kay Red-

Too, the illness has given me an empathic connection with other people's frailty, the realization that in meetings, in social exchanges, people talk around and around the one thing that they cannot and will not say and how this refusal becomes a mask, a personality. But one cannot feed on this; it is not nourishing. Still it irks me. My one gift — to detect falsity. But it cannot be said.

He is watching; he is waiting. He will give me the opportunity to say some of this, to blurt out what I really think, in anger. It will mark me, set me apart and he will turn a childish circle, hands in his pockets, and walk off.

I once thought that by immersing myself in his surroundings, the field of psychiatric disabilities, I could come to understand him, Manic Depression, and work through the issues. It has not worked out, just as this article will neither fully explain me, nor excuse me from the consequences of my decisions.

The path I chose, of publicly educating others about mood disorders has led to a cul-de-sac where the echoes of voices identifying me with my relentless nemesis and thus dismissing me are far too strong. At times I cannot distinguish those voices from my own self-judgments. It has played out. He knew it would play out, he knew it would bother me too much, involve me to a punishing extent with prejudices I was powerless to change. He loved it when

someone called me "high-functioning." He knew I would flinch and squirm.

Still, I have come to know him a little. I know what he hates, Manic Depression. He hates involvement. He hates to be imperfect. He hates all the countless compromises and everyday tradeoffs of adult life. He hates to fit in, though this is what is expected.

Above all he hates it when I am satisfied and happy: his fists knot in his pockets when he sees me laughing with others, playing with my daughter, working with a purpose, relaxing.

"What's the matter with you!" he cries on the street corner. "Expand, transcend, flee, run, soar, burn out, crash, huddle, suffer! The thrill! The very thrill!" And he opens his jacket to show me his trinkets again and I see them clearly: the locks of my true loves grown grey and brittle, the books mildewed, the print bleeding in black wisps, the watches tarnished, stopped. He stamps his feet. Shall we leave him there? ■

Speaking of Depression: The Language of Mood Disorders

Nan Dickie

Nan is a freelance writer living in Vancouver.

Not long ago, I read an article where depression was described as a "dragon" and a "challenging foe" that we "try to defeat with pharmacological weapons." I reacted strongly to this choice of terms and to picturing mental illness in such a confrontational way. As a person with a 40-year history of unipolar mood disorder, I'd like to offer a different perspective on the use of language for this illness.

At one time I, too, thought of depression as a savage beast that I must try to obliterate, as a red-hot dragon that I must flee from, or as a deadly demon that I must annihilate with drugs. I came to realize, however, that if I tried to "kill" my illness, I would have to kill myself. Over the course of many years, I

tried every weapon at one time or another to relieve the symptoms of my illness: intelligent reasoning, denial, spirituality, will power, medication, and meditation, to name a few.

Sadly, none of these techniques had any long-lasting, positive effect on the sorry state of any particular episode. These attempts did not help me conquer depression, nor make the enemy retreat. In fact, at times these activities directed against a foe seemed to fuel the fire of depression. I would end up feeling like a failure — a loser in this impossible fight. My feeling of self-worth would be brutally diminished, if not demolished.

In recent times, I have tried to view my episodes differently.



Dealing with Past Trauma and Mental Illness

Bill Davidson

Bill is a former child and youth care worker, who worked primarily in residential treatment in a variety of roles from 1967 to 1995. Since 1995, he has been permanently disabled with bipolar disorder. Bill self-publishes "Healing Normal." (www.cs.ualberta.ca/~davidson/billious)

Rather than using provocative words such as dragon and foe, I now use words that, to me, acutely describe the intensity of the experience, admitting to its awful reality, without giving depression the power of an enemy. I now use terms such as "the Black Pit" and the "the Ominous Presence." Admittedly, these are not exactly emotionally-stripped terms. However, with "Black Pit," I have had some success in wrapping depression into a shape that has dimensions that are less than infinite. With "Ominous Presence," I acknowledge depression's omnipresent darkness without bestowing it with hate.

In recent times when I have become depressed, I have tried to remind myself that I have a biochemical brain irregularity, some faulty wiring that causes intolerable pain. (Given the nature of the disorder, however, I am not able to believe these facts while I'm in an episode.) I try to hold on to the fact that being depressed is not my fault though it is my brain's flaw. I try to remember that the enormous gap in my life during an episode is due to the synapses in my brain.

I've been learning to view the seeming monster as something I must unfortunately live with, respond to, and, I believe, respect. I no longer pretend that this illness isn't with me. I must "own" my body chemistry. I can't go back to the proverbial blackboard to redesign myself and start again. Depression is in me and of me. I am trying to love myself in spite of this hardship and the despair it brings. It seems that it is contradictory to both love myself and to seek to defeat an enemy within at the same time.

Until medications are able to deal with every twist and turn of depression, I know I must accept the painful effects of this unwelcome, permanent resident in my body. I must accept the periodic invasion of the symptoms that the illness brings me.

I try to shed at least a modest amount of healing light on the irrepressible blackness. I attempt to counterbalance depression's brute strength with my "weapons" of self-acceptance, patience, and trust in my close friends and family.

No words will ever rid me of this illness. But after years of searching for language to help me live with recurring depressive illness, I have chosen to describe it with compassionate, yet poignant, language. ■

In her book *Trauma and Recovery*, the award-winning Associate Clinical Professor of Psychiatry at the Harvard Medical School, Judith Lewis Herman, writes: "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma." To say that I was startled and intrigued to read those words would be an understatement. I got goose bumps.

Definitions

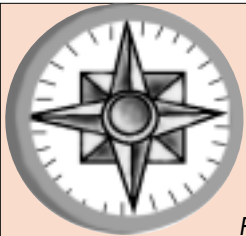
The clinical category "Post-Traumatic Stress Disorder" (PTSD) came into being not as a result of any initiative by mental health professionals but because of advocacy by veterans of the Vietnam War. It was the voices of returning combat veterans announcing their invisible psychological injuries, loudly and persistently, that compelled the professional community to overcome its initial skepticism and to investigate their proclamations more exhaustively. And unlike vets of

World War 1 and World War 2, Vietnam vets were not welcomed home as heroes. We owe them our gratitude.

Terms such as "shell shock" and "combat fatigue" come to us from WW1 and WW2. While the terms labeled the same phenomenon, there wasn't a solid base of professional or public understanding, nor were there support services available for returning combatants of these earlier wars.

While it may not compare with the trauma experienced by war veterans, psychological trauma occurs elsewhere and it debilitates. Post-traumatic phenomena likewise abound and it very often is not recognized. It is often unrecognized in mentally ill persons, and its manifestations (or results) are all too often swept into the particular psychiatric label of an individual, rather than being addressed for what they are.

... The uncovering of the reality of psychological trauma ►



A Map for the Journey: By Nan Dickie

Many compelling questions face those who live with recurring depression, including "How can I make sense of the world?" and "How can I find meaning and live a productive, fulfilling life when so much of it is interrupted by my episodic illness?" For all those difficult questions — individuals with depression, their families and supporters, educators and counsellors, indeed all of us — *A Map for the Journey: Living Meaningfully with Recurring Depression* has been written to help provide some answers.

This book doesn't tell how to cure depressive illness. Neither does this book pretend that the illness is easy to manage. But with a mix of stories, articles, and essays, it leads readers through a variety of scenarios and approaches, drawing them towards some useful solutions and guidelines that will help better manage devastating depressive episodes. It offers gentle, practical suggestions.

A Map for the Journey will be published by AmericaHouse Incorporated, and will be available early next year in bookstores and on the internet through amazon.com or ericahouse.com.



in its many forms is not complete. Our awareness of the extent of psychological trauma in our midst today remains wanting. We are perpetually poised at the cutting edge of history.

Excerpted from "Healing Normal", Issue No. 1.

While psychological trauma does not necessarily mean life-long pain, we have learned that recognition of the trauma itself is essential in the path of liberation from post-traumatic phenomena. My own recent history bears witness to these facts.

Invisible Trauma

... A cascading sequence of inter-connecting events sustained and nourished post-traumatic symptoms and these incessantly contaminated all aspects of my life and the

lives of all who are close to me. A key ingredient in this was that post-traumatic symptoms were attributed to my dramatically emergent mental illness. A profound sense of abandonment set in.

Being seen as mentally ill is not a lot of fun. The reactions of those around me, though well-intentioned, have sometimes been excruciatingly painful. The minimization and denial of the traumatic nature of some events has been devastating. This seems to have occurred out of a lack of knowledge and awareness — which is why I have suggested that my experience takes place at the boundary of knowledge.

Becoming Traumatized

In my former life I was a hard-working child and youth care worker. I enjoyed a positive

reputation. I was noted for my ability to tolerate high levels of stress. I lived by my well-honed crisis intervention skills and my creativity. A broad spectrum of people trusted me and respected me. A sense of humour was my calling card. Then I burned out on the job and was propelled in just a few weeks into the eye of a world-class manic break. My former life ended at that point.

As I booked off work in a state of the most profound exhaustion that I can recall experiencing, I did not anticipate that within days I would be face down on the asphalt outside of the psychiatric ward of our community hospital.

I self-admitted into the psychiatric ward last night. I don't feel comfortable here. I

decide to check out, to go to a friend's organic, country home in California. I want a safe place. I am being informed, over the desk at the nurse's station, with patients, guests and cleaning staff present, that I am being committed. (A private and confidential communication would have been less provocative!) Now I am shocked, at peak rawness, and revved beyond control. I run.

I make it as far as the parkade. Three security guards are holding me face down. Someone's knee is in my kidneys. Now both arms are being wrenched behind my back. I am yelling at one security guard to take it easy on my left shoulder, "It was broken last summer!" He is jerking it up higher, re-injuring it. I am escalating into hysteria.

I am struggling and am being carried back into the ward. I am thrown into a small featureless locked room in the "Special Care Unit." I wail and flail on the door with my fists. The three security guards are storming into the room now. They are holding me down and are struggling to undo my belt and zipper, trying to get my jeans off. I see two female nurses watching. I am in terror. "I can do it myself!" I am screaming. They are letting me strip by myself. I am putting on hospital pajamas. I am demanding to phone a lawyer.

One security guard snarls, "You don't have that right! This isn't jail!"

From that moment, my life path was cast into a set of experiences so horrible that I could not have even imagined them in my prior life. There were four more hospitalizations in the two years following my involuntary committal, totaling over three months.

My obsession with this event and the security guard who deliberately injured me, who intimidated me during a subsequent admission, was seen by all, inside the hospital and outside, as a manifestation of the bipolar disorder — likewise my persistent sense of abandonment.

Finally, in the summer of 1998, I tracked down a psychologist specializing in post-traumatic recovery. We had four sessions. The first two were spent getting in touch with one another. The third one was the actual traumatic incident debriefing, and the fourth one was a wrap-up session.

In my case, a single session produced remarkably positive results. I understand that

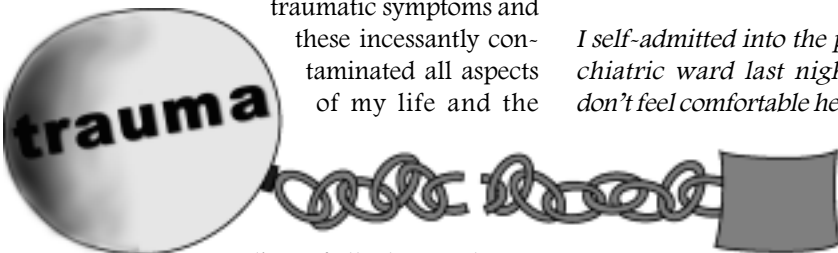
in some cases it may take longer. I was invited to begin at the beginning of the traumatic incident in the hospital and to describe fully what happened to me, on a moment-by-moment basis. The psychologist would at various points ask for greater detail and would frequently ask for emotions to be verbalized. It was that simple. Details that had been lost in my inner turmoil became clear. My emotional states were honoured. Intentions at each step of the experience were clarified and accepted fully.

The traumatic incident debriefing itself took about 45 minutes. Having been repeatedly told to "let it go" or to "get on with your life" prior to this, the sense of relief and release was palpable. The affirmation, by a trauma specialist, that I had indeed been traumatized was like salve on a festering sore. Even bipolars can experience trauma. No kidding.

Since then I have not obsessed about that incident, though I can still get a mild heat on for a few minutes if I think about it on purpose. I have become more able to relieve some other traumas and episodes of abandonment on my own. Goes to show that symptoms are not solely bipolar: bipolar, not bonkers... It is not my intention to attack our local psychiatric ward, a critical care facility that saves lives daily ... but I challenge those in the field to recognize post-traumatic phenomena and the impact of their possibly unnecessary invasive interventions. ■

Related Resource

McGorry, P., et al. (1991). "Post-traumatic stress disorder following recent onset psychosis." *Journal of Nervous and Mental Disorders*, 179: 253-258.





My Daughter is My Guardian Angel

Donna Lea
Zwick

Four months after my second child, a daughter, was born, I strolled along the boardwalk of Steveston pier with my husband, children, and my children's godparents. It was an unusually bright and warm early spring afternoon and I was in a particularly joyous mood.

I had spent the last week with a specialist who told me I had manic depression in combination with seasonal affective disorder. I also suffered a rarer form of seasonal affective disorder in which, instead of sleeping excessively, I developed insomnia with the shorter days and darker skies. The specialist prescribed numerous drugs for me to take for the first two weeks, after which she would work out some maintenance prescription that I would take for the rest of my life. She further recommended I not consider having any more children, as I would suffer a severe breakdown should I have a third.

Breastfeeding would have to stop, as the drugs I was prescribed would pass into my breast milk and could affect my daughter. Why I was so joyous certainly had nothing to do with how I was physically feeling, because the drugs were knocking me for a loop and I felt distinctly crappy. And I wasn't particularly overjoyed to be diagnosed as mentally ill. I am a registered nurse — mental illness isn't an asset. "Hi, my name is Donna, I'm manic today and I will be taking care of you. ROLL OVER! And don't worry if the injection isn't in the right place — my medication tends to make my eyesight blurry ... Sir, where do you think you're going?"

No, I felt joyous because for the first time in more than 20 years, I finally learned why I have always felt different. Since the early '80s, I have been in and out of hospitals for breakdowns, seeing various psychiatrists and doctors. I suffered emotional damage due to misdiagnosis, improper treatment, personal denial, and guilt over broken relationships. For years, I considered myself damaged goods and unworthy of love and attention.

In March of 1993, I suffered a severe breakdown. It took until the end of that summer to gain enough confidence to return to a fraction of my normally energetic self. I married in November and by August of the next year I gave birth to my son and, 14 months later, my daughter.

I noticed no postpartum depression with my son, but my daughter's early infancy was troubled. I had bled during my pregnancy and, after fighting to keep her in my womb for 38 weeks, I finally gave birth. It was October, clouds were rolling in and the days were getting darker. Seasonal affective disorder was plaguing me, but I tried to ride a high of new-baby happiness. By February, I was riding high all right, but more due to exhaustion, tension, and weeks of little to no sleep. I was seriously losing perspective.

I remember calling a friend to babysit my children while I ran to the library. Looking up seasonal affective disorder, I found on the exact opposite page a description of postpartum depression. I immediately knew this was my problem. I visited a specialist the next day and started medications.

You may not see my turnaround as a big deal. But I had been fighting my head demons for 20 years with very little proper medical attention. As a nurse, I had denied their existence was anything more than a fault in my upbringing and personality. There were no lab tests, CAT scans, X-rays, or ultrasounds that could tell me what I had. So, if it could not be measured, in my mind it had to be my fault.

My daughter changed my attitude. To take care of her the very best I could, I had to confront my illness head on, take whatever treatment and medications I needed, and begin to understand and trust how the "new me" thought and felt. My daughter is truly my guardian angel — she survived a problematic pregnancy so that I could finally be taken care of. Her birth and her life have brought me my own health.

I wonder what is in store for my son and daughter as they grow up. I worry about the mental illness in my family that stretches back at least two generations and encompasses more than half of all my living relatives. However, I know now that with my decades of experience, along with my wisdom as a nurse, I trust my instincts and judgment when it comes to my children, their behaviour, and their idiosyncrasies. And when I am uncertain, I do not hesitate to ask a professional for answers.

I feel joyous in ways some mothers will never know. I feel extra good when I get through a stressful day at work or at home without feeling like I need to run away from life for a while. I pride myself when, instead of being completely furious about some incident, I can get ticked, talk about it, and laugh it off. I feel lucky to be able to share my illness with my present colleagues who neither judge nor condemn me. This has not been the case in most other nursing jobs I've had where a code of silence still operates in the mental health arena. ...

I feel happy when my husband notices things I now do with ease, that two or three years ago I would not have mastered. I feel lucky that the medications give me almost no side effects and that my ability to create, concentrate, and poke fun at myself is sharper than ever. I am lucky to have my husband and son. My daughter, though, will always be the one who saved me from myself. No, I don't spoil her more than my son. I just remember that day at Steveston and what her life has given me. ■

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In this section, we examine some of the alternatives and approaches that have helped people with mood disorders return to a normal life. After looking at an overview of some of the most prominent approaches, we'll take a closer look at the closely related approaches of cognitive behavioural therapy (sometimes simply known as "cognitive therapy") and psychoeducation, and then highlight the efforts being made by people with mood disorders to educate themselves, through the internet, and within the self-help movement. Then we'll focus in on emerging approaches, in particular on early intervention and prevention of mood disorders in youth and adults.

Treatment of Depression

Raymond W. Lam, MD, FRCPC

(This article is continued from page 5 although it can be read on its own).

Major depression is one of the most treatable conditions in medicine and there are many effective treatments available. Unfortunately, many clinically depressed people never get treated. There is still stigma attached to having a mental disorder that prevents many people from seeking help. Sometimes they do not recognize that their symptoms are treatable, and sometimes their depression is unrecognized by health professionals. An Ontario study found that 90% of clinically depressed people had seen a family physician within the previous few months, but only 50% received treatment for their depression. The other 50% were untreated; of these, half declined treatment due to stigma and the other half were "living with it." Even for the people receiving treatment, only a minority was receiving effective treatment for depression.

The objectives of treatment for depressive disorder are: 1) to reduce and remove the physical and psychological symptoms of depression, 2) to restore role function, and 3) to prevent relapse and recurrence of depression. In the past 20 years, a number of proven effective treatments have been studied. These include new antidepressant medications, specific focused psychotherapies such as cognitive behavioural therapy

(CBT) and interpersonal psychotherapy (IPT), electroconvulsive therapy (ECT), and light therapy.

Antidepressants

Antidepressant medications have been used for over 50 years and there are over 20 antidepressants currently available. The newer medications (the Selective Serotonin Reuptake Inhibitors, starting with Prozac in 1988) specifically affect different neurotransmitters in the brain. Not only are they as effective as the older medications, they are safer and have far fewer side effects. Unfortunately, there is no particular symptom or blood test that allows us to determine which antidepressant is best for an individual patient. The choice of an antidepressant is often based on the side effects that may occur. Regardless, about 75% of people improve when they take antidepressants for clinical depression. For instance, Alice, the lawyer we met earlier in this issue of *Visions*, was initially concerned about taking medications, but after using an antidepressant for a couple weeks, started feeling better. After two months, she was feeling almost back to her usual self and able to return to full-time work.

People are often uncertain about taking medications for their depression. They may discontinue the medications before they experience any benefits because they have unfounded negative beliefs

about antidepressants. Five simple messages from the clinician to address some of these mistaken beliefs have been shown to greatly improve compliance to antidepressant medications (see Table 1 below).

Psychotherapies

Psychotherapies are also effective for treating clinical depression. There are many different types of psychotherapy, but the best validated treatments are "short-term" psychotherapies consisting of 12 to 16 sessions, once or twice a week. Several studies have shown that these psychotherapies are as effective as medications for some types of depression. Combination antidepressant and psychotherapy treatment may be most beneficial for people who are not responding to one or the other. Unfortunately, there is still limited access to these validated psychotherapies in the community.

Cognitive behavioural therapy (CBT) is based on the

recognition that depressed people have negative thoughts and pessimistic thinking patterns that contribute to their depression. They may dwell on the negative aspects and discount the positive aspects of a situation, and will "catastrophize" when trying to problem-solve. These "cognitive distortions" result in learned maladaptive behaviours. In CBT, the depressed person learns to identify and test these negative cognitions and learns practical strategies to break the negative cycle. CBT involves keeping track of mood states and doing homework assignments to practice what is learned during the sessions. When Roger underwent CBT and learned to reverse his negative thinking pattern, his mood improved and he became more socially active.

Interpersonal psychotherapy (IPT) is based on the recognition that depression is associated with significant relationship problems that either predate and contribute to the illness, or that are consequences of having a

Table 1: Five Messages to Improve Antidepressant Compliance	
1	Take the medications daily
2	The medications are not addictive
3	Antidepressants do not work immediately, and it may take two to four weeks before you start feeling better
4	Do not stop taking your medications without checking with your doctor, even when you feel better
5	Mild side effects are common, especially at the beginning of treatment, and will usually improve once your body gets used to the medication



clinical depression. IPT starts with a detailed assessment of current and past relationships and then focuses on the most pressing problem such as unresolved grief, social role disputes, social role transitions, or social isolation. Practical strategies are then learned to deal with the problem relationship. Sarah found that IPT helped her to focus on her marital issues and family roles. Once these were addressed, her depression improved.

Some depressed patients improve with antidepressants, others improve with psychotherapy, and still others need a combination of treatments to show most benefit. Again, we cannot yet predict who will do best with which treatment, and in some cases it is a matter of personal preference whether to take medications or to undergo psychotherapy.

Other Biological Treatments

There are, however, people with severe or difficult-to-treat illnesses who clearly require biological treatments. For some of these patients, electroconvulsive therapy (ECT) is often the

best treatment. Contrary to the usual negative public perception of “shock therapy,” modern ECT is a very safe and effective treatment for clinical depression. During ECT, an electrical stimulus is administered to produce a seizure in the brain lasting 60 to 90 seconds. A general anesthetic and muscle relaxants are used so patients are asleep, and there is no muscle response during the seizure. Patients are carefully monitored during the procedure and usually require about eight treatments over the course of three or four weeks. There are some side effects associated with ECT, in particular a temporary short-term memory disturbance for around the time when patients are getting ECT. Studies using detailed neuropsychological tests found that six months after a course of ECT, there were no intellectual or memory differences between those depressed people who received ECT and those who did not.

This procedure can be a life-saving treatment for patients who are severely suicidal or who have severe symptoms like psychosis. For example, Maria, the 72-year-old woman who was having hallucina-

tions during her depression and was at high risk of suicide, recovered completely after receiving a course of ECT. ECT can be effective even when antidepressants have not worked, but it is an expensive treatment because it needs to be done in hospital. We recently reviewed ECT use at UBC Hospital. Of the 130 patients treated over a two-year period, 88% were rated as improved after ECT, compared to only 12% who had little or no improvement. Even though patients were rated only a week after the ECT was completed, only 6% of patients had troublesome memory disturbance.

Light therapy is another biological treatment for people with winter depression, a form of Seasonal Affective Disorder (SAD). Light therapy consists of sitting in front of a bright, fluorescent light box for about 30 minutes a day, usually in the early morning. About two-thirds of patients with SAD respond within a week or two to this simple treatment, although they need to continue light treatment throughout the winter. We don't know exactly how light therapy works, but the two main theories are: 1) that light affects the bio-

logical clock in the brain, which may have difficulty adjusting to the changing light levels in the winter, or 2) that light affects neurotransmitters like serotonin.

In summary, major depression is a very common illness in the general population and health professionals will certainly encounter many patients who are clinically depressed. Sarah, Alice, Roger and Maria illustrate the many faces of clinical depression that makes it challenging to recognize. The causes of major depression are not known but there are likely multiple biological and psychosocial contributing factors. There are many effective biological and psychological treatments for depression, and one can be optimistic that patients with clinical depression can feel better and recover to resume their normal lives. ■

Related Resources

Canadian Network for Mood and Anxiety Treatment (CANMAT) at: www.canmat.org

Depression Information, Education, and Resource Centre (DIRECT) Toll-free Public Line: 1-888-557-5051 (ext. 8000); Physician Line: 1-888-557-5050 (ext. 800) or go to www.fhs.mcmaster.ca/direct

Cognitive Therapy for Depression

Betsy Jacobson of Brewster, NY, had grappled with the crippling effects of depression and a deflated ego almost her entire life. Reared in a domineering family with a controlling father, she was unable to fulfill her ambitions and use her talents as an actress. “I was scheduled to fail at everything I did,” she recalled in an interview. Years of psychotherapy, including analysis, did nothing to ease her psychic pain — nothing, that is, until she began seeing a cognitive therapist. Cognitive therapy helps to improve people’s moods and behaviour by changing their faulty thinking, how they interpret events, and talk to themselves. It guides them into thinking more accurately and realistically and teaches them coping strategies to deal with problems.

“He saved my life,” Mrs. Jacobson said emphatically of her cognitive therapist. “At age 52, I was suddenly able to grow an ego. The difference in the therapeutic approach was dramatic, and the relief I felt was immediate. Instead of dwelling on the negative, which the other therapists did, and which only ground my ego further into the ground, the cognitive therapist treated me like a decent, respectable human being with valid feelings. A healthy sense of myself was drummed into my head while I learned how to change my thoughts and feelings.”

“In midlife, I finally became a free woman, a person with self-respect,” she continued. “I could start a brand-new life and do

Jane E. Brody



things Betsy wanted to do, not just what my family wanted me to do.” Although Mrs. Jacobson returns to the therapist occasionally for booster sessions, she said, she has acquired therapeutic tools she can apply on her own, in case she finds herself slipping into old patterns of thought or behaviour.

Cognitive therapy is, in most cases, a short-term treatment that can have long-term results. Typically, less than three months of weekly sessions can achieve therapeutic benefits that may take years to accomplish with traditional talk therapy. That alone suggests that cognitive therapy will enjoy an ever-widening role in the treatment of emotional disorders.

Many, if not most, people have no coverage for outpatient psychotherapy, and medical insurers and managed-care providers who offer such benefits usually strictly limit their duration.

Furthermore, studies have shown that the results of cognitive therapy are long-lasting, with relapse rates far lower than with other modes of treatment, including psychiatric drugs. And while medication is sometimes used, at least briefly, to relieve acute emotional disturbances and improve receptivity to therapy, most patients can be spared the side effects of drugs, which may include loss of libido (sex drive) and inability to function sexually, gastrointestinal upsets, sleep disturbances, and difficulty concentrating.

Mrs. Jacobson’s experience with cognitive therapy is hardly unique. While no one approach to psychotherapy is suitable for everyone, many thousands of patients have benefited from the strategies unique to cognitive therapy.

In the 30-odd years since the approach was developed by Dr. Aaron T. Beck, a world-renowned psychiatrist at the Beck Center for Cognitive Therapy in Philadelphia, it has become the most scientifically tested form of psychotherapy. Independent studies have shown that cognitive therapy is as effective as medication and traditional psychotherapy in helping patients who suffer from depression, anxiety disorders (including panic attacks) and bulimia, according to professional analyses and a recent survey by Consumers Union. Cognitive therapy is also proving useful for patients with chronic or recurring pain. Mrs. Jacobson, for example, said the therapy had helped her enormously in coping with the symptoms of fibromyalgia, chronic muscle pain.

A cognitive therapist directs a patient’s attention to “automatic” thoughts, the things people say to themselves that

result in unpleasant feelings. For example, someone prone to

anxiety attacks might automatically think, “I’m going to mess up,” when taking an exam, participating in a social event, or being interviewed for a job. After failing such a challenge, the person may conclude, again automatically, “I’m a loser.”

In therapy, the person is helped to recognize errors in thought, which include exaggerating the sense of threat, anticipating disaster as the likely outcome, overgeneralizing from one negative experience, and ignoring times when things went well.

Once damaging automatic thoughts are recognized, the person is helped to examine how realistic they are, consider alternative explanations, imagine other outcomes, and realize that the symptoms of anxiety are not the prelude to a heart attack or some other medical disaster.

A similar approach is taken with depression. Dr. Judith S. Beck, Dr. Aaron Beck’s daughter and the current director of the Beck Institute, said depressed patients have continual unpleasant thoughts and that each such thought deepens the depression. Generally, however, these thoughts are not based on facts and result in feelings of sadness far beyond what the situation warrants.

“Depressed persons make such mistakes over and over,” the Becks have written. “In fact, they may misinterpret friendly overtures as rejections. They tend to see the negative, rather than the positive side of things. And they do not check to determine whether they may have made a mistake in interpreting events.”

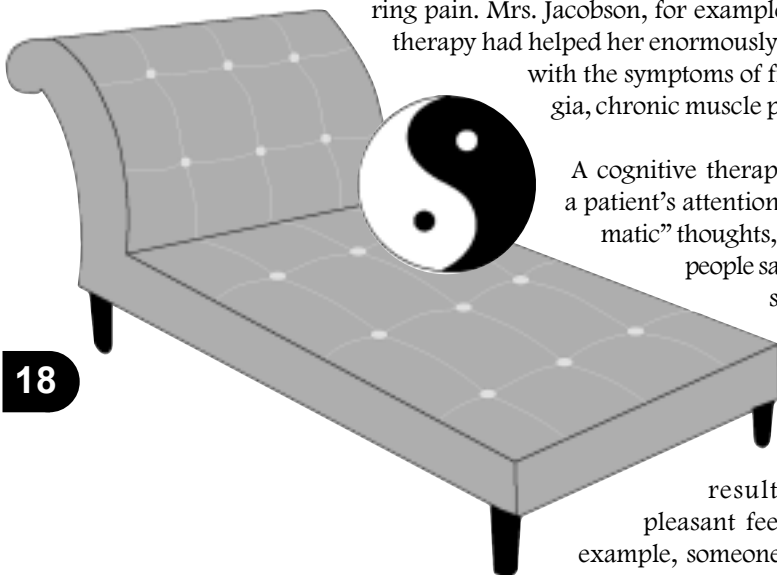
Rather than delve into the origins of such negativism, cognitive therapists teach patients to identify their negative thoughts, recognize their mistaken nature and devise a corrective plan that leads to more positive assessments and an ability to deal more realistically with day-to-day problems. Dr. Frances M. Christian, a clinical social worker and cognitive therapist at the Medical College of Virginia, explained: “Thoughts and beliefs have a lot to do with how people feel and behave. Early in life, people develop core beliefs about themselves and other people and about how the world operates.” For one reason or another, some people develop negative core beliefs that distort their interpretations of events and their predictions about their lives.

Christian said: “Because cognitive therapy focuses primarily on the present and is problem-specific, patients generally are not in therapy for a long time, and they learn coping skills they can use throughout their lives. Much of the learning takes place outside of the office. It’s a self-help approach, and the therapist acts like a coach, helping the patient acquire coping skills.”

Finding Help

The techniques of cognitive therapy can be applied in individual counseling and in group, family and couples therapy. The professionals trained in cognitive therapy include psychiatrists, psychologists and social workers. ■

Reprinted from an article in the New York Times: August 21, 1996.





Exporting the Treatment of Depression: The Changeways Experience



In 1991, psychologists Dr. Peter McLean and Dr. Bill Koch at UBC Hospital noticed a gap in Vancouver's mental health services. People receiving inpatient care for major depression would eventually be discharged from hospital, but there were few resources to help them in the next phase of their recovery. The doctors received a grant from the BC government to test-run a group-based psychoeducational program for depression. This program, which began in 1992, was designed to teach clients much of what was known about effective management strategies for depression and to assist them in putting this knowledge into practice in their own lives.

A subsequent evaluation of the first year of the program revealed that 9% of program participants were re-hospitalized within 6 months — compared to 30% of non-participants in a comparison group. As well, scores on standard measures of depression and related difficulties declined, and consumer feedback was extremely positive. Based on the re-hospitalization data alone, it appeared to be cheaper to fund the program than not to fund it.

The program model was acknowledged to be a success, and Changeways was made an ongoing program of Vancouver Hospital and Health Sciences Centre with a dual mandate: 1) to continue to offer the program to those recently discharged from inpatient care for mood disorders, and 2) to teach providers at other agencies how to offer

similar programs as part of their own services. Initially, the goal for the outreach component was to form links with up to three agencies in different regions of the province.

Several years have now passed, and Changeways has developed considerably. Our on-site program now consists of a variety of elements. Clients are referred from agencies throughout the Lower Mainland and are seen once they are out of hospital. Upon acceptance into the service they attend the Core Program, a seven-session group providing training in a variety of lifestyle-based treatment strategies for depression.

These include goal-setting techniques, ways of overcoming depressive "inertia," the roles of diet, exercise, and sleep, ways of building social contact and support, cognitive strategies for dealing with the negative thinking so prevalent in depression, and relapse prevention techniques. At every session, participants set achievable goals for themselves to carry out before the next meeting. As part of the program they receive an 86-page manual of depression coping techniques.

Clients complete an extensive battery of psychological tests before and after the Core Program and at six-month fol-

low-up. Most participants also consent to have us track their admissions to hospital over the next five years. It is hoped that by monitoring readmissions we can more readily identify the predictors and effective treatments of recurrent depression.

Once participants have been through the Core Program, they have a variety of options. They can sign on for our 6-session training in relaxation techniques. They can attend an 8-session assertiveness training group. They can bring their family and friends to a single-evening lecture on depression recovery. They can also attend our monthly follow-up support program, 'Changeways Continues.' Meetings of 'Changeways Continues' provide a forum for the sharing of experience and progress and typically include an educational component. Some topics covered in the past year include an update on medications, "coming out" about depression to others, the role of perfectionism in depression, and anger management strategies.

The outreach education component of the program has gone far beyond the initial goal of three outside agencies. Staff from over 200 BC mental health services have attended Changeways training workshops, and programs based directly on our

models have been offered in 40 communities across the province (including multiple locations in the Lower Mainland). The Department of Canadian Heritage has funded the translation of our materials for clients into Chinese, and Changeways is now being offered in Cantonese by several agencies in the Lower Mainland. News of the program has spread beyond the borders of BC: training workshops have been provided in Alberta, Ontario, Prince Edward Island, Yukon, Australia, and Hong Kong. We have records of over 4000 clients attending Changeways-based groups so far. Not bad for a service with only three clinical staff, two of them half-time!

Recently Changeways has become affiliated with the Mental Health Evaluation and Community Consultation Unit (MHECCU), which has enabled the hiring of an additional half-time psychologist and an expansion of the outreach training program. Changeways now has its own web site designed mainly for mental health service providers (www.changeways.com) and is developing additional resource materials for mental health services throughout BC. ■

Randy Paterson,
PhD

Randy is
Coordinator
of the
Changeways
Program.

Changeways is: nurse Sarojni Rajakumar, office manager Elizabeth Eakin, psychologist Dave Erickson, and coordinator/psychologist Randy Paterson. Changeways currently offers four training workshops for mental health providers: Group Treatment of Depression, Relaxation Skills, Assertiveness Training, and Sexual Orientation Issues in Healthcare. For information on workshops, call (604) 822-7153.



Hope Through Knowledge:

www.mentalhealth.com

Robert Winram

Robert is the Executive Director of the Mood Disorders Association of BC.

Dr. Phillip Long was visiting Japan six years ago when he suddenly realized that there is a great variation in care delivery and knowledge among countries, as well as among outlying districts within countries. At that time, he had developed a computerized psychiatric diagnostic program for doctors, but he thought this application could be broadened and made available to everyone. As the project grew, there was an obvious need to organize and make available generalized information relating to the various diagnoses. Huge amounts of data needed to be reviewed so that his site would have the capacity to focus on the best information and the most useful points of view.

Information on medications is clearly an important part of this resource, but the value of client-centered treatment is certainly stressed. There is much more to "treatment" than the abating of symptoms. Much work needs to be done so that those who live with these illnesses can maximize their quality of life. To this end, Dr. Long developed a quality of life questionnaire that can be printed as a graph. This allows individuals to chart their progress on a weekly basis. In this way they can see how they are doing and also identify their strengths and weaknesses in combatting symptoms.

The most popular feature of the site is the section that enables a visitor to learn more about diagnoses for each mental illness. After a diagnosis is indicated, it is possible to access relevant treatment guidelines. These are drawn from psychiatric associations, particularly the Canadian and American ones. In this way a person receives a type of second opinion that might be informative or thought provoking. The web site also allows the user to selectively retrieve the best research in the world

for each mental disorder and look up medication side effects.

At this site, there are stories of recovery that include tips on ways to overcome illness. The web site also offers a free book written by a group of individuals suffering from schizophrenia; another one on mood disorders is nearing completion.

Dr. Long is encouraged by the number of people visiting the



site: there are over 6000 new visits a day to the home page with 110,000 pages downloaded a day. Approximately 12 million people have visited since 1995.

There is so much suffering that need not be. The pattern of mental illness is well documented by science; we know it can be managed. We must communicate the good news about recovery. There is no longer a need to hide conditions behind walls of stigma. Mental illness can be dealt with, and people can enjoy the happy fulfilled lives that they deserve. This site is one of the tools toward that end. ■

The Role of Support Groups in Recovery from Mood Disorders

Barbara Bawlf

Barbara works at CMHA BC Division in the area of consumer issues and peer support.

Ever since I was diagnosed with depression thirteen years ago, I have found that there is more to treatment and recovery than just medication. Supports in the community such as family, friends, and recreational facilities have all helped, but the most beneficial resource for me was the Mood Disorders Support Group in Victoria.

Ironically, it was a psychia-

trist that alerted me to the existence of what was then called the Manic-Depressive/Depressive Support Group. He had seen an advertisement for a meeting on the Rogers Cable community announcements. Although the doctor and I were unable to continue our relationship, I will always be grateful for this information.

I had first experienced the

symptoms of depression seventeen years previous to my diagnosis, so it was a relief to finally get a name for my condition and to know that there was treatment available.

My first visit to the support group proved a great boost to my mental health. There were about twenty people sitting around a table in a big house in Esquimalt, owned by the mother of one of the

participants. We went around in a circle, and everybody talked about how they were doing. After the process was complete, I could feel my mood lifting substantially. Here were a group of people who actually understood what it was like to feel the way I felt. I didn't have to explain that my mood was not a result of bad weather, a broken relationship or grief. The people in the room would not



Early Detection of Adolescent Depression

ask stupid questions as to the reason for my sadness. Furthermore, the severity of the problems I heard about seemed so much more serious than my own; strangely this helped immensely. If these people could get up and about while under the burden of such terrible pain, then certainly I could.

I continued for many years, on and off, to visit the support group, whether I felt I needed it or not, thinking that the very act of going would be preventative. There were people I met there that today are still friends, so it also acted as a social network.

The support group played a major role in my recovery by giving me a safe place to speak about my experiences with depression. I think for most people that attend such groups, an environment is created that provides empathy and education as well. We would often have guest speakers, and people exchanged information on medications, doctors, and alternative treatments.

It is difficult when dealing with the symptoms of a mood disorder to merely take a handful of pills each day and expect to feel 100% better. My experience was that once the symptoms had been treated and I felt physically more healthy, then I needed to go out and seek support in order to get back into society. The support group offered me the way in, guiding my path to recovery.

Today, there are dozens of support groups around BC. To find one near you, call the Mood Disorders Association at (604) 873-0103 or the Mental Health Information Line at (604) 669-7600 or toll-free at 1-800-661-2121. ■

Depression is a common disorder which tends to begin in adolescence and which can recur in adulthood. The literature suggests that one in five adolescents in the community have emotional disturbance. Both boys and girls share increasing levels of depression in puberty, but the rate of increase is faster in girls. Depression is significant because of its association with harmful behaviours and mortality in all age groups.

During adolescence, there is a rise in the onset of tobacco, alcohol and drug use, eating disorders, and mortality due to suicides. Young people who experience depression are at an increased risk for engaging in these harmful behaviours. Adolescence, therefore, is a key time for early detection of and early intervention in depression. Early intervention may do much to promote well-being and to prevent future suffering of affected individuals and their families. It can also be cost-efficient by comparison to later intervention.

Adolescents experience remarkable physical and psychological changes. Their social environment allows increased independence and decision-making over many domains, including health. As they arrive at this age, they are better able to think and talk about health and illness in terms of emotional, intellectual, and social aspects. They are also able to view their behaviour as having an impact on their health. Adolescents' mental health is influenced by their concepts and reasoning regarding their social world. Cognitive development is deeply embedded in adolescents' perception of self, their identity in relationship to others, to society, and to the world. These aspects are critical in their ability to recognize signs of depression in themselves.

Self-recognition of early signs of depression in adolescence is essential for early detection of depression. Studies show that about one in four young people perceive themselves as having emotional disorders. Their capacity and understanding of depression will affect their timely judgment to access appropriate support.

Adolescents' help-seeking behaviour for depression and their attitude to seeking help from doctors and counselors are also critical to early support and treatment for young people experiencing depression. Help-seeking may begin after one has recognized a problem and thinks it is important enough to get help for it. Help-seeking for depression remains an unexplored territory. The ability to recognize and assess one's need for help is a skill influenced by maturity and experience. Delays or inabilities to access care may be partially explained by young people having difficulties in recognizing their own disturbances, by the severity of the disturbances, by adolescents' coping resources, their attitudes and beliefs about seeking help, and the visibility and acceptability of available services. Adolescents' understanding of and attitude to depression will determine whether they think their symptoms are important and serious enough to seek help. What adolescents think and do about depression influences the service delivery structure.

Delays or incapacities in obtaining help and treatment nearly always have negative effects on the individuals experiencing depression, their families, and society as a whole. Current approaches to service provision are also likely to fail adolescents who recognize depression and do not seek help. Adequate access to care is further compromised when adolescents who present to services do not fulfill clinical criteria for depression. Treatment for depression needs to be more flexible and responsive to the needs of the affected individual. It should also be negotiated with those who require, but instinctively reject, services currently offered. ■

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Czesia
Fuks
Geddes

Czesia is an Interdisciplinary PhD student at the University of British Columbia (UBC). She is based at the Institute of Health Promotion Research. Her research focuses on adolescent mental health.



Early Detection of Bipolar Disorder

Eric Macnaughton

Eric is Policy and Research Coordinator at CMHA BC Division.

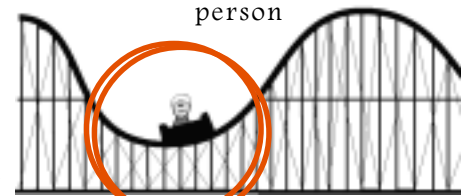
The BC Early Intervention study showed major problems with respect to the early detection and diagnosis of people with bipolar illness. Once in contact with the mental health system, over half of the overall study sam-

ple received an incorrect initial diagnosis. From point of first contact with the system, people with bipolar disorders, on average, waited over twelve more years before finally receiving the correct diagnosis and the improved

treatment that often followed from this.

While much of the attention in the early intervention field is presently focused on schizophrenia or “early psychosis,” research from around the world shows that long delays in correct identification are a common occurrence for people with bipolar disorder. As with schizophrenia, it is likely that longer delays are associated with poorer treatment outcome. Prominent researchers argue that misdiagnosis and mistreatment of bipolar illness as “depression” may lead to an overuse of antidepressant medications, and that these medications, in turn, may make the illness harder to deal with.

polar illness seek help. In the BC study, people with bipolar illness usually sought help during the “down” phase of their illness. The final “trigger” leading them to reach out was often an inability to cope with their day-to-day life or a suicide attempt, despite earlier periods of mania or “hypomania” (less severe mania). In these instances, details of the high phase of the illness were usually not volunteered, and were often seen as unrelated to the illness by the person



him or herself. Study participants often commented that they had seen their high phases as “who they were,” and often valued the productivity and confidence that came with them. As one person said, his high phase was seen as “successful, work-driven activity.”

A number of similar studies have shown an initial misdiagnosis rate of between 40 and 60% of people with bipolar disorder. It has also been reported that people may see three or four professionals, typically over a period upwards of ten years before being recognized as having bipolar illness. There is evidence that approximately 30% of cases of “major depressive disorder” within primary or specialist care settings actually fall into the bipolar “spectrum” of disorders. Other research shows that bipolar disorder (with psychotic features) may be incorrectly diagnosed as schizophrenia and bipolar disorder with rapid cycling or “mixed” states may be incorrectly diagnosed as borderline personality disorder.

It appeared that mental health professionals, for their part, did not inquire in much detail about the past fluctuations of moods or activity levels in people who seemed to have simple depression. One participant in the BC study, when asked by the researcher whether her depressive “crashes” were preceded by extended periods of high activity (she answered yes), replied that no professional had ever asked this question. She remains diagnosed as “depressed,” despite her own belief that her true diagnosis is bipolar illness, and has been unsuccessful in her attempts to seek a second opinion.

What is accounting for all of this? Part of the reason relates to the reasons people with bi-

Cross Cultural Suicide Prevention

Michael J. Chandler and Christopher Lalonde

This research report examines the concept of “self-continuity” and its role as a protective factor against suicide. First, we review the notions of personal and cultural continuity and their relevance to understanding suicide among First Nations youth. The central idea developed here is that, because to somehow count oneself as continuous in time is essential to one’s identity, anyone whose identity is undermined by radical personal and cultural change is put at special risk of suicide, for the reason that they lose those future commitments that are necessary to guarantee appropriate care and concern for their own well-being.

It is for just such reasons that adolescents and young adults who are living through moments of especially dramatic change constitute such a high-risk group. This generalized period of increased risk during adolescence can be made even more acute within communities that lack a sense of cultural continuity, that might otherwise support the efforts of young persons to develop practices which strengthen their sense of “a continual self.”

We present data to demonstrate that, while certain First Nations groups do in fact suffer dramatically elevated suicide rates, such rates vary widely across British Columbia’s nearly 200 Aboriginal groups: some communities show rates 800 times the national average, while in others suicide is essentially unknown. Finally, we demonstrate that these variable incidence rates are strongly associated with the degree to which British Columbia’s 196 bands are engaged in community practices that are indicators of a collective effort to rehabilitate and ensure the cultural continuity of these groups. Communities that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are dramatically lower. ■

Excerpted from Transcultural Psychiatry at www.mcgill.ca/psychiatry/transcultural/tpr.html Volume 35 #2 (June 1998)

Related Resources

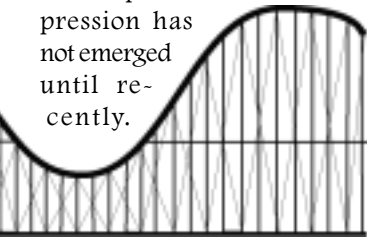
The Mind of a Child, award-winning National Film Board documentary about youth suicide among First Nations communities.

Rouse, D. (1998). “Suicides Among Young Aboriginal Women in BC.” Lifelines: A Suicide and Community Health Newsletter, 3: 12.



Other research highlights this same basic pattern for people who seek help for “depression”: previous “high” periods are not seen by them as related to their current reason for seeking help and the relevant details are, therefore, not offered. This “cross sectional” approach to assessment by mental health professionals fails to uncover the true picture of the illness.

Another factor accounting for lack of early identification is that knowledge about the relationship between bipolar and unipolar depression has not emerged until recently.



Newly presented evidence is showing that in addition to hypomania (or Bipolar II), there is a continuum of disorders between classic mania and strict unipolar depression. The research also suggests that the prevalence of disorders within the bipolar part of the spectrum may be as high as 5% (rather than the traditionally-cited figure of 1%), and that these disorders often masquerade as unipolar depression, and are therefore under-recognized in clinical practice.

People with Bipolar II, on close examination, often have a history (either prior to development of their illness or between episodes) of a personality trait known as “cyclothymia,” which is characterized by cyclical variations in energy level, shifts from positive to negative mood, and a tendency to daydream. Further, it is argued, that a group of people who have been previously diagnosed with unipolar de-

pression, actually fit a newly proposed “Bipolar III” category. These people have a history of “hyperthymia,” that is a characteristic personality trait of being hard working, cheerful, and energetic. In the *BC Early Intervention study*, these were the people who typically described the high energy prior to the onset of their illness as being “just who I am,” or referred to themselves as “always being a hard worker.” Bipolar III is the designation of this “hyperthymic” state.

The promise of this new approach to diagnosis is that the “high” side of the bipolar spectrum illnesses can be recognized and dealt much earlier than is presently the case. With respect to medication, this means more use of mood stabilizers, rather than antidepressants alone, so that the manic or hypomanic pole of the illness is controlled. As noted above, inappropriate use of antidepressants may worsen the illness, and may in fact trigger a manic episode. The other side of the equation is that the stressors (e.g., overwork, sleep deprivation, substance use, etc.) that are so often part and parcel of the lifestyles of those with a cyclothymic or hyperthymic temperament can be seen for what they are and kept in check. ■

Selected References

Akiskal, H. & Bowden, C. (2000). “The Spectrum of Bipolarity.” Symposium at American Psychiatric Association’s 153rd Annual Meeting.

Cassano, G., Dell’Osso, L., et al. (1999). “The bipolar spectrum: A clinical reality in search of diagnostic criteria and an assessment methodology.” *Journal of Affective Disorders*, 54 (3): 319-328.

Macnaughton, E. (1999). *The BC Early Intervention Study*. CMHA, BC Division.

Family Matters: Supporting Parents with Mood Disorders and Their Children

Lyne Brindamour

I work in an Intensive Family Program as a Family Counsellor. I work with mothers, fathers, children, and relatives who are often coping with a lot of stress. Some of the parents have mood disorders and are often busy looking after their own needs like medical appointments, bad and good days, side effects of medication, and community expectations.

Parents with mood disorders are not only looking after their individual needs, but with the particular needs of their children as well. All children I work with are busy with their own stages of development and special emotional needs. Every family I come in contact with is quite unique and has its own vision of how they want their family to be together and its own hopes about the future. My role is to stand back and listen to all family members. Usually I am told quite openly about how my presence in the home could be most useful for the family. In one particular family, I was told that talking for one hour about practical issues, such as meal suggestions, children, friendship, hobbies, is as (or even more) helpful as having a formal counselling session. Another parent indicated that the most supportive service she ever had was a homemaker twice a week, so she could sleep and adjust to the new role of being a parent with an infant.

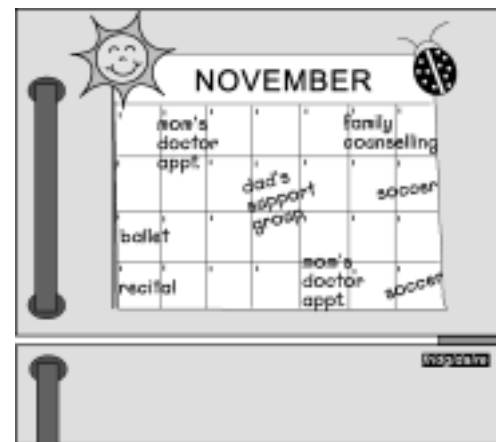
Some parents mention that their relationship with their children is difficult and want to explore new ways of interacting with them. A resource that they have found helpful is the workbook *Someone In My Family Has A Mental Illness*. This is an educational workbook created for children between ages seven and fourteen. It was designed for counsellors, other community mental health professionals, and for parents and caregivers who wish to educate their children about mental illness. To order *Someone in My Family Has A Mental Illness*, contact Family Services of the North Shore at (604) 988-5281. You can also e-mail them at family@familyservices.bc.ca ■

Related Resources

For an article describing a program supporting children of parents with depression, see www.mhsource.com/put/p990957.html

All Together Now: How families are affected by depression and manic depression, a booklet based on a cross-Canada research project examining the issues of families living with mood disorders. Features a special focus on the issues of adult children of parents with mood disorders. For ordering information, see Health Canada’s web site at www.hc-sc.gc.ca

Lyne Brindamour is an Intensive Family Counsellor at Family Services of the North Shore, in North Vancouver.





In this section, we examine some of the key factors that affect the development and course of mood disorders. There are a number of things that affect the possibility that someone may develop a mood disorder, or influence the eventual outcome of that condition. In this regard, there has been much attention to factors such as age (youth are more at risk of depression, while the elderly appear to be more vulnerable to succumbing to suicide), gender (women are twice as likely to develop depression), and to family background (those with a family history are more likely to develop a mood disorder). However, in this section we'll take a closer look at a finding that is just beginning to emerge: that is, the close relationship between mood disorders and physical health issues such as lifestyle, stress, and other medical conditions.

Double Trouble: Depression and Co-existing Medical Illnesses

Sarah
Hamid

Consider the following scenario: if you go to your doctor complaining of headaches, he or she is not likely to announce “headache-itis” as the diagnosis and send you on your way. Headaches are a sign. Yes, they can be signs of head trauma, tumour, or migraine, but more commonly they are clues to other illnesses or environmental influences that frequently exhibit headaches as a symptom. After all, who hasn’t had an allergy headache, tension headache, hunger headache, eyestrain headache, or even a headache caused by sleeping in on Saturday morning? Depression and other mood disturbances are exactly this complicated.

Sustained changes in mood can be signs of many things. They might indicate one of the various forms of clinical depression. They could be related to a number of other medical conditions that have depressed mood as a common symptom. Or both of these could be (coincidentally) happening at the same time. In fact, the latter is probably more common than people realize. Data from the Mental Health Supplement to the 1994 Ontario Health Survey shows that of people who had a mental disorder in the past year, a full 72% also had one or more physical health problems (see Figure 1).

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Below is a list of illnesses that might be implicated when you go to a health care practitioner concerned about depressive symptoms. We’re not trying to scare you. It’s important to know this not just for general education, but so that you make sure you tell your doctor about other physical and environmental influences in your life, and so that your doctor tests you for some of these other illnesses if you show signs of depression. Knowing the full context of your health is important for making an accurate diagnosis and suggesting appropriate courses of treatment — that responsibility is yours as much as it is your doctor’s.

Depression and Heart Disease

Depression often goes unrecognized and untreated when it coincides with chronic illnesses like heart disease. Though depressed feelings can be a common reaction to both the diagnosis of heart disease and the lifestyle changes it demands, depression that lasts several weeks or months is *not* the expected reaction and may in fact be clinical depression.

Studies abound investigating the link between heart disease and depression. Montreal researchers have found that depressed patients who have had heart attacks are four times

more likely to die within six months as their non-depressed counterparts. Depression also seems to be an independent risk factor for coronary heart disease in the older population. For those with the highest scores for depression, the risk for heart disease increased by 40% and the risk of death by 60% compared with those with the lowest depression-symptom scores.

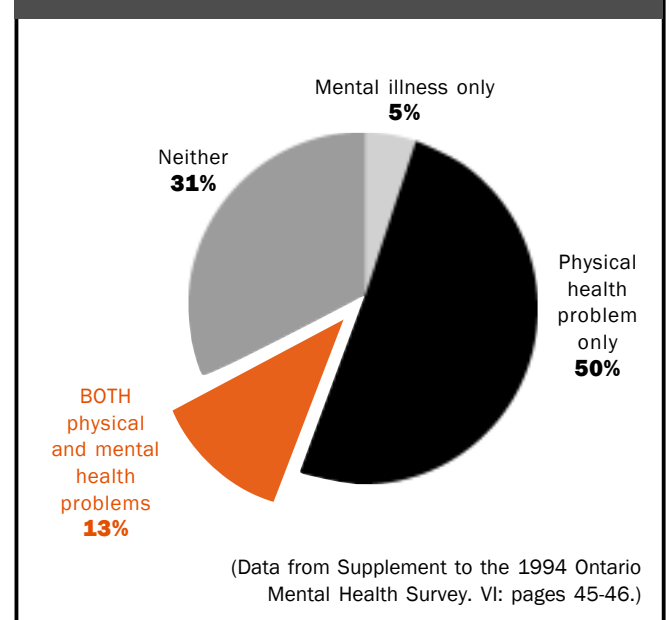
One theory behind the relationship is that depressed people make poor lifestyle choices — particularly around diet and exercise — and that those with an existing heart condition may not be motivated to take heart medication regularly. Another theory suggests that stress is the common denominator because stress, and the effects its hormones wreak on the body, has known links to both depression and heart problems.

For more on this topic, consult the resources below or read the article on page 31.

Related Articles

- “Depression and Heart Disease” (www.suite101.com/article.cfm/depression/41789)
- “Co-Occurrence of Depression with Heart Disease” (www.nimh.nih.gov/publicat/heart.cfm)
- “Depression Can Break Your Heart” (www.nimh.nih.gov/publicat/heartbreak.cfm)

Fig. 1: Mental and Physical Health Problems





Related Organizations

- Heart and Stroke Foundation of Canada (www.heartandstroke.ca)
- BC Head Office: (604) 736-4404 (www.hsf.bc.ca)
Toll-free: 1-888-HSF-INFO
- BC Heart Health (www.heart-health.org)

Depression and Stroke

Even when the blood clot is not in your heart (heart attack) but in your brain (stroke), there are similar risks for depression. Research shows that about one-third of stroke survivors experience depression after their stroke. Post-stroke depression appears common, with women and people with more education at higher risk. One major problem in diagnosing depression in this population is that some of the symptoms used to classify depression can also be the direct result of brain damage resulting from the stroke. Going through a depression after something as life-changing as a stroke is understandable but, even so, it should not be ignored. Researchers have noted that post-stroke depression can have a significant impact on people’s ability to recover. In studies, the depressed group tend to repeatedly exhibit significantly lower daily living and activities ratings. Helping the depression can help rehabilitation.

Related Articles

- “Co-Occurrence of Depression with Stroke” (www.nimh.nih.gov/publicat/stroke.cfm)
- Paolucci, S. et al. (1999). “Post-stroke depression and its role in rehabilitation of inpatients.” *Archives of Physical Medicine and Rehabilitation*, 80: 985-90.

Related Organizations (see previous section)

Depression and Cancer

Like heart disease and stroke, cancer is a chronic illness that can be accompanied by a major depression. Adapting to such a major negative life event can no doubt be stressful and depressing and may take several months of adjustment; however, if after that time, symptoms of depression persist or worsen, there may be something else afoot that warrants investigation. Increased risk for depression is especially the case if the cancer is impeding your ability to go to work or carry out daily activities, interfering with your social activities or relationships, causing you severe fatigue or pain, or is a progressed or relapsed cancer. Diagnosis and treatment of co-existing depression can bring many benefits: improved quality of life and motivation, improved cooperation with doctors and treatments, and reduced pain since both naturally occurring and synthetic antidepressants also have a pain-blocking effect.

Related Articles

- Aass, N. et al. (1997). “Prevalence of anxiety and depression in cancer patients.” *European Journal of Cancer*, 33(10): 1597-604.
- “Co-Occurrence of Depression with Cancer” (www.nimh.nih.gov/publicat/cancer.cfm)

Related Organizations

- Canadian Cancer Society (www.cancer.ca)

- BC Division: (604) 872-4400 (www.bc.cancer.ca)
- Cancer Information Line: 1-888-939-3333

Depression and Diabetes

A diagnosis of diabetes is a painful thing to swallow at any time in your life. And when you’re depressed about a major life change and challenge, you’re probably less likely to exercise enough, eat responsibly, or take your medicine regularly — all of which feeds into a vicious cycle that makes both your diabetic and depressive conditions worse. Some research suggests that depression may not just be a complication of diabetes but also a potential trigger. I can’t even begin to unravel this complicated relationship in such a short space. To learn more, read the article on page 28.

Related Articles

- “Depression and Diabetes” (www.suite101.com/article.cfm/depression/42236)
- “Diabetes, Depression, and Stress” (www.ncpamd.com/dmdepression.htm)
- Goodnick, P. J. et al. (1995). “Treatment of depression in patients with diabetes mellitus.” *Journal of Clinical Psychiatry*, 56(4): 128-136.

Related Organizations

- Canadian Diabetes Association (www.diabetes.ca)
- BC Division: (604) 732-1331
Toll-free: 1-800-665-6526
- Diabetes Resource Centre Information Line: (604) 732-4636 or 1-800-268-4656

Depression and HIV

By now, I’ve probably driven home the point that people managing life with a chronic medical condition are more likely to go through major depression than people who don’t have a physical health problem. HIV and AIDS are no different than heart disease, stroke, cancer, or diabetes in this respect. However, people living with HIV and depression have added challenges: they have to live with the double stigma of HIV and mental illness; their depressive symptoms might actually be an early sign of other AIDS-related conditions; their support networks are not always the healthiest; and certain populations living with HIV might more easily turn to substance abuse as a coping mechanism for depression. Since new treatments are being developed all the time that are extending the lives of people infected with HIV, there is every reason to believe treating a co-existing clinical depression is worth it in the long run and can improve both a person’s quality of life and motivation.

Related Articles

- “Depression and HIV” (www.nimh.nih.gov/publicat/hivdepression.cfm)
- “Depression and HIV: Assessment and Treatment” (hivinsite.ucsf.edu/topics/mental_health/2098.44d1.html)
- numerous articles on depression and HIV (www.thebody.com/mental/stress.html#depression)



Related Organizations

- Canadian AIDS Society (www.cdnaids.ca)
- BC Persons with AIDS Society: (604) 681-2122 (www.bcpwa.org)

Depression and Thyroid Disease

If you go to your doctor complaining of depressive symptoms, you will probably be asked, like I was, to undergo at least a couple of blood tests, one of which will gauge the level of thyroid hormones in your blood. A “hyper” or overactive thyroid can result in symptoms resembling anxiety. A “hypo” or underactive thyroid is associated more with physical and mental lethargy and fatigue. Therefore, when presented with a case of depression, physicians will usually test for underlying hypothyroidism since most of these patients have some degree of associated depression. According to the Thyroid Foundation of America, since most cases of underactive thyroids begin after age 50, symptoms are often mistakenly linked to aging, menopause, or regular depression. So get your thyroid examined. If the blood test does show you have a hormone deficiency, thyroid hormone therapy will often clear up the depressive symptoms. If not, the depression may have been co-occurring, in which case you can and should still be treated for it as a separate illness.

Related Articles

- “Depression and Thyroid Disease” (thyroid.about.com/health/thyroid/library/weekly/aa120897.htm)

Related Organizations

- Thyroid Foundation of Canada (home.ican.net/~thyroid/Canada.html)
- BC chapter: (604) 266-0700

Depression and Asthma/Allergies

Emotional distress like depression or anxiety can bring on an asthma attack. “When I see patients who are having severe attacks, I always ask them, ‘What’s gone wrong in your life?’” says H. James Wedner, chief of allergy and immunology at Washington University School of Medicine in St. Louis. In fact, researchers have found that severe depression and anxiety more than doubled a nonsmoker’s risk of developing asthma. Why does this link exist? Several theories exist, all of which may be true: depression weakens the immune system, thereby making it easier to react to allergens or develop a respiratory condition; depression changes levels of hormones and brain chemicals which might set the stage for development of asthma; and depressive states can make heart rate and blood oxygen levels erratic, which might also increase the chances of a pending asthma attack.

Asthma is not the only allergic state with a link to mood. Allergic rhinitis (think hay-fever symptoms like a runny, stuffy nose, sneezing, and itchy eyes) is also associated with higher rates of depression. Studies suggest a high rate of atopic disorder (a hay-fever-like allergy that is probably inherited) in people with depression. One theory is that allergic reactions can accentuate neurochemical activity imbalances in the nervous system in a way similar to depression. When this happens

to that small subgroup of people already at a genetic risk for depression, symptoms of depression can be produced and/or heightened by the allergic state. I find this a particular interesting finding because I have an inherited allergy and a genetic risk for depression. The allergy and depression flared up at the same time in my life. Until researching this article, I never understood why.

Complementary medicine proponents also argue that depression can be a symptom of a food allergy. Talk to your doctor and naturopath further if you feel your bouts of depression are connected to something in your diet (members of the grain family, egg whites, and molds are often the first suspects).

Related Articles

- “Allergies and other forms of sensitivity” (www.wellness.demon.co.uk/allbro~1.htm)
- “Asthma: The Mind-Body Connection” (www.ahealthyme.com/topic/depasthma)
- Cuffel et al. (1999) “Economic consequences of comorbid depression, anxiety, and allergic rhinitis.” *Psychosomatics*, 40(6): 491-496.
- “Depression and Allergies” (www.greatsmokieslab.com/assessments/finddisease/depression/allergies.html)
- Marshall, P. S. (1993) “Allergy and depression: A neurochemical threshold model of the relation between the illnesses.” *Psychological Bulletin*, 113(1): 23-43.

Related Organizations

- Asthma Society of Canada (www.asthma.ca)
- Allergy Asthma Information Association (cgi.cadvision.com/~allergy/aaia.html)
- BC chapter: (250) 861-6590
Toll-free: 1-877-500-2242

Depression and Sexual Dysfunction

Sexual health has a lot in common with mental health. Each can affect the other. Each can also, as we have seen so far, be affected by co-existing medical or psychological conditions. When we experience sexual dysfunction, that is, our sexual functioning is not quite right, depression can sometimes be the culprit. After all, if you’re in a depressed state, you probably aren’t interested in much of anything — sex included. Conversely, sexuality is such an important part of our self-worth and identity, that if you’re having problems in the bedroom, the sense of inadequacy or failure could spur on a bout of depression. Yet another cause: medications for many illnesses (including, but not limited to, depression itself) can impair sexual performance, so talk to your doctor and pharmacist about side effects. For information on the sexual side effects of psychiatric medications, see the issue of *Visions* on Sexuality and Relationships. The good news is that many of the newer antidepressants, for example, have minimal or no sexual side effects.

There’s also a fourth possibility: that another medical or psychological illness could explain both the disturbances in mood and sexual functioning. Underlying physical conditions that can cause sexual problems include diabetes, heart disease, neurological disorders, pelvic surgery or trauma, chronic dis-



ease like kidney or liver failure, hormonal imbalances, alcoholism and drug abuse, or heavy smoking. Psychological causes can include stress or anxiety from work, concern about poor sexual performance, marital discord, unresolved sexual orientation, a previous traumatic sexual experience, and, of course, depression. Once the cause is sorted out, the good news is that sexual problems are highly treatable. Talk to your doctor and be patient — especially if depression is the cause. As my doctor once told me, “sexual side-effects are often the first symptom of depression to appear and the last to go away.”

Related Articles

- Dunn, K. M. et al. (1999). “Association of sexual problems with social, psychological, and physical problems in men and women: A cross sectional population survey.” *Journal of Epidemiology and Community Health*, 53(3): 144-148.
- Ellery, D. “Medications and Sexual Problems.” (1999). *Visions: BC’s Mental Health Journal*, 8: 24-25.
- Michael, A. & O’Keane, V. (2000). “Sexual dysfunction in depression.” *Human Psychopharmacology: Clinical and Experimental*, 15(5): 337-345.
- “Silence About Sexual Problems Can Hurt Relationships” (www.ama-assn.org/insight/spec_con/patient/pat039.htm)

Related Organizations

- SIECCAN - Sex Information and Education Council of Canada (www.sieccan.org)
- Health Canada: Sexual and Reproductive Health (www.hc-sc.gc.ca/hppb/srh/)
- Sexual Health Network - Sexuality and Disability or Illness (www.sexualhealth.com)
- Canadian Urological Association ‘Links’ (www.cua.org)

Depression and PMS

One of the first questions my doctor asked me when I told him I was depressed was “When and how often?” He asked me to keep a ‘depression diary’ for a month to see if there were any patterns to my depression. It turned out not to be hormonal in my case — good thing too, because it had never occurred to me to think of my period as a potential cause. Unfortunately, a lot of women make the opposite mistake and assume “it’s just PMS” when in fact that’s only part of the story.

It is estimated that between 30 to 70% of women experience pre-menstrual symptoms in the week leading up to their period. About one in twenty of these women have symptoms severe enough that day-to-day functioning and relationships are seriously affected; they are usually diagnosed with premenstrual dysphoric disorder (PMDD) or what most people refer to as PMS (pre-menstrual syndrome). PMDD/PMS is characterized by irritability, moodiness, crying spells, and physical complaints like bloating, headaches, lethargy, and changes in appetite. Even women who know they are going through an ongoing clinical depression are not immune to the effects of PMDD/PMS. Often, these women’s symptoms are alleviated for much of the month and suddenly break through in the premenstrual phase of their cycle. For mild cases of PMDD/PMS, changes in diet can be helpful such as reducing

salt, caffeine, and alcohol, and resisting cravings for junk food. Women also find relief from relaxation rituals, exercise, and sometimes counselling. More severe cases often require medication such as antidepressants or hormone therapies, in addition to these lifestyle tips.

Related Articles

- “Premenstrual Dysphoric Disorder” (www.wellmother.com/pms.htm)
- “Pre-Menstrual Syndrome (PMS) or Pre-Menstrual Dysphoric Disorder (PMDD)” (www.bcrmh.com/disorders/pms.htm)

Related Organizations

- Canadian Women’s Health Network (www.cwhn.ca)
- British Columbia Reproductive Mental Health Program: (604) 875-3060 or (604) 875-2025 (www.bcrmh.com)



Depression and Digestive Function

Several studies have noticed an association between depression, anxiety, and digestive disorders such as Irritable Bowel Syndrome, Crohn’s Disease, and ulcerative colitis. On the one hand, digestive disorders are chronic illnesses that affect major aspects of a person’s daily routine, including their emotional coping mechanisms. On the other hand, the excess release of stress hormones and digestive acids — common during bouts of depression and anxiety — is known to aggravate digestive disorders. Making poor dietary choices when you’re in psychological distress may also play a role in upsetting the delicate balance of your intestinal network. Treating underlying depression and anxiety, as well as taking periodic diet and stress management courses can go a long way to providing gastrointestinal relief.

Related Articles

- “Depression and Digestive Function” (www.greatsmokieslab.com/assessments/finddisease/depression/digestive_function.html)
- Heretik, A. et al. “Affective symptomatology in patients with non-specific inflammatory intestinal disease.” *Ceska a Slovenska Psychiatrie*, 90(2): 91-96.
- Hochstrasser, B. & Angst, J. (1996). “The Zurich study: Epidemiology of gastrointestinal complaints and comorbidity with anxiety and depression.” *European Archives of Psychiatry and Clinical Neuroscience*, 246(5): 261-272.
- Trikas, P. et al. (1999). “Core mental state in irritable bowel syndrome.” *Psychosomatic Medicine*, 61(6): 781-88.
- Zubenko, G. S. et al. (1997). “Medical comorbidity in elderly psychiatric inpatients.” *Biological Psychiatry*,

▲
a family
doctor and
psychiatric
professional
working
together



41(6): 724-736.

Related Organizations

- Crohn's and Colitis Foundation of Canada (www.cccf.ca)
- BC Chapter: (604) 685-1844; Toll-free: 1-888-685-1844

Depression and Bone Loss

According to a 1996 study by the National Institute of Mental Health, depression may increase a woman's risk for broken bones. Mineral density (a key factor in bone strength) in the hip bones of women with a history of major depression was found to be 10 to 15% lower than normal for their age — so low in fact that the researchers estimated the increased risk of hip fracture was as much as 40% over 10 years. As one scientist put it, "The affected women in this study, average age 41, had bone loss equivalent to that of 70-year-old women. More than a third faced a markedly increased risk of fracture."

One probable cause is excess secretion of the stress hormone cortisol, which is known to cause bone loss and is a common feature of some forms of depression. Supporting evidence comes from studies which showed that women with past or current depression do have higher amounts of cortisol in their urine and that higher amounts of cortisol in the urine are associated with more fractures. So what about men? When both sexes were tested, bone loss was found to be greater for men than for women. Among the implications of all these research findings is that depression could be a significant risk factor for developing osteoporosis at a relatively young age. (Postmenopausal women do not appear to be at the same risk).

Related Articles

- "Depression Linked to Bone Loss"

(www.nimh.nih.gov/events/prbones.htm)

- Michelson, D. et al. (1996). "Bone mineral density in women with depression." *New England Journal of Medicine*, 335(16): 1176-1181.
- Schweiger, U. et al. (2000). "Low lumbar bone mineral density in patients with major depression: Evidence of increased bone loss at follow-up." *American Journal of Psychiatry*, 157(1): 118-120.
- Schweiger, U. et al. (1994). "Low lumbar bone mineral density in patients with major depression." *American Journal of Psychiatry*, 151(11): 1691-1693.
- Reginster, J. Y. (1999) "Depressive vulnerability is not an independent risk fact for osteoporosis in postmenopausal women." *Maturitas*, 33(2): 133-137.

Related Organizations

- Osteoporosis Society of Canada (www.osteoporosis.ca)
- OSTOP (Osteoporosis Society of BC): (604) 731-4997
Toll-free: 1-800-363-1933 ■

General Resources

Ontario Ministry of Health (1994). "Mental Disorders and Physical Health." *Ontario Health Survey: Mental Health Supplement*. VI: 45-48.

"Depression Co-Occurring with General Medical Disorders" (www.nimh.nih.gov/publicat/co_oc.cfm)

"Depression Rates in People with Co-Existing Medical Illness" (www.mentalhealthscreening.org/brochure/index.htm)

"Depression in People with Chronic Illness" (www.uncg.edu/edu/ericass/depress/docs/chronic.htm)

"The Unrecognized Link: Depression Co-Occurring with Medical Conditions" (www.nimh.gov/publicat/unrec.cfm)

Depression and Diabetes

Jasmeet
Bhullar

Because of its prevalence, depression has been referred to as the "common cold" of psychiatric illnesses. While common in the general population, depression is approximately three times more prevalent in people with Type 2 diabetes (later onset diabetes), and possibly just as high for people with Type 1 diabetes (known as "insulin dependent" diabetes or formerly known as "juvenile diabetes"). It has been estimated that the average person with diabetes has one episode of depression per year. For people with more serious depression, diabetes increases

the rate of recurrence. For people with both conditions, once depression has been recognized and treated, significant improvements result in the management of each illness. In this article, we look further at the complex relationship between these two health conditions. Quotes by Chris Laird, a person who lives with depression and diabetes, will illustrate key points.

The Association Between Depression and Diabetes

The relationship between depression and diabetes can occur in both directions: that

is, having diabetes may increase the likelihood of becoming depressed (or more depressed); on the other hand, people who are depressed have a higher likelihood of developing diabetes (or worsening this condition). In either case, the relationship involves many other biological and psychological factors, as we'll explain below.

How Pre-existing Depression Can Influence the Development and Course of Diabetes

While not proving a causal link, one study showing that

people with diabetes had an increased likelihood of having depression prior to developing diabetes suggested a possible mechanism for how depression can lead to diabetes: pre-existing depression may lead to inactivity and overeating, which may result in obesity. Obesity, combined with a family history of Type 2 diabetes, then increases the risk of a person developing this kind of diabetes.

Pre-existing depression can also worsen the course of diabetes for a person who already has it. In this scenario, a lack of motivation — due to



depression — may lead to poor self-care behaviours such as obesity, smoking, alcohol abuse, and physical inactivity. These factors, in turn, may lead to poor diabetes management and possible complications.

As Chris Laird explains, “When I’m depressed, I tend to overeat, making it difficult to control my sugar levels...I eat more, feel worse, eat more, feel worse...”

How Diabetes Can Influence the Development and Course of Depression

Poor glucose control, an aspect of diabetes, may be a risk factor for depression. Research has shown that hyperglycemia (chronically high blood sugar levels) can lead to biological changes in mood, including feelings of fatigue and depression. Even after depression is treated, hyperglycemia can bring on new episodes of depression.

There are a number of other diabetes-related factors that can impact depression:

- The emotional burden of being newly diagnosed

with diabetes can lead to depression, or worsen a pre-existing depression.

- Dietary restrictions, blood-testing routines, hospitalization, and increased financial obligations of diabetes may make people more prone to depression.
- Managing diabetes can be stressful. Stress can cause hyperglycemia and can also aggravate depression.

Figure 1 (below) illustrates the cyclical relationship between the two conditions.

Treatments

Below we’ll discuss some of the unique benefits (or risks) that various forms of treatment can offer to people with both diabetes and a mood disorder.

Psychotherapy

As has been discussed elsewhere in this journal, psychological treatments such as cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) — sometimes alone, and sometimes in combination with other forms of treatment — are effective

forms of support for people with depression. People with diabetes are no exception, and in fact may gain increased benefit. Given their high vulnerability to relapse and given the emphasis of psychotherapy on learning skills for dealing with stressful situations, CBT can therefore help prevent recurrences of depression.

Antidepressants

Selective Serotonin Reuptake Inhibitors (SSRIs) are the most commonly prescribed type of antidepressant for people with diabetes. SSRIs can help decrease appetite, which may be beneficial for someone who has depression and is overeating, by helping to control blood glucose levels. However, some antidepressants can have side effects such as weight gain and vomiting, which can negatively affect glucose levels. It is important that frequent blood testing is done to monitor any changes; that way, your physician can make any necessary changes to your insulin dosage.

For those taking additional medications due to diabetes complications, the possibility of drug interactions must be taken into account. It is important that the psychiatrist and/or other clinicians are aware of all medical problems in order that the medication list can be reviewed, appropriate medications can be prescribed, and interactions can be monitored.

Improving control of blood sugar levels

As previously mentioned, chronically and frequently elevated sugar levels can lead to mood changes and depression. Once glucose levels are within a normal range, people find that their mood

brightens. Although treatment of depression cannot solely focus on diabetes management, improving diabetes control will help people feel better emotionally, mentally, and physically.

Chris Laird explains his own experience: “When I take my insulin adequately, my mood improves, I have more energy, and I sleep better.”

Lifestyle and self-help measures

Exercising regularly, eating well-balanced meals, avoiding alcohol, and learning relaxation techniques will not only help relieve your depression but will also help regain control of your diabetes. Feeling or becoming isolated is a symptom of depression. As difficult as it may be, people should talk to a family member or friend about their feelings. Joining a support group can help you meet others who are going through similar experiences and can offer understanding and support.

Chris Laird agrees: “I do a lot of volunteer work and try to learn new computer programs ... you have to keep yourself mentally and physically active. This raises my self-esteem and helps with my depression. When I feel myself falling into a depressive episode, I spend time with people I feel comfortable with. It’s a rough world out there...you need to be around people you trust and can talk to.” ■

Selected References:

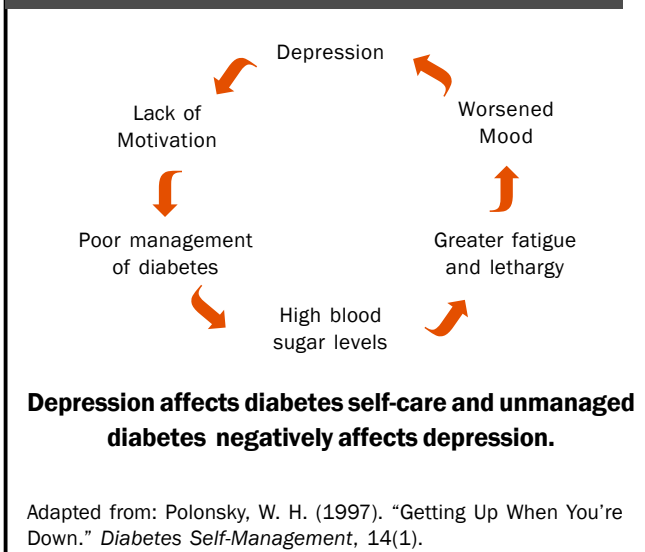
Visit www.intelihealth.com/IH/ih/IH/EMIHCO00/333/333/286457.html

“Depression and Diabetes,” by John McManamy. Please see www.suite101.com/article.cfm/depression/42236

Refer to the list of depression and diabetes articles on page 25.

Jasmeet is an SFU student who recently completed a co-op placement at CMHA BC Division. She is in the process of completing a brochure on depression and diabetes, a joint-project between CMHA BC Division and the BC/Yukon Division of the Canadian Diabetes Association.

Fig. 1: The Cyclical Relationship Between Diabetes and Depression





Developing Objective Laboratory Diagnostic Services in Mental Health

HeartLink Canada (1999) Inc. will introduce a new methodology for documenting physiological dysregulation associated with psychiatric illness for use by the physician community. Objective test data captured by the patient wearing a non-invasive, unobtrusive, lightweight monitor supports the physician's clinical observations and knowledge in diagnosing mental health conditions such as depression and anxiety.

The service will provide a prompt, written laboratory report, in electronic or fax format, based on objective measurement of patient physiological markers and other convergent information. It will also assist in monitoring the effectiveness of prescribed treatment. The service is being developed across Canada, commencing in British Columbia in Spring 2001 and will provide physicians with easy access to a centralized laboratory system.

Proud to be associated with
Canadian Mental Health Association's
National Depression Screening Day
and
Mental Health in the Workplace Programs

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Heart Disease and Depression: Like Fish and Bicycle?

When you saw the words ‘fish’ and ‘bicycle’ in the same line, you probably failed to see a connection between the two — and so you should. Heart disease — which is clearly seen as a physical disease — and depression may at first glance seem to be as closely linked as the ‘fish’ and the ‘bicycle.’ The purpose of this article, of course, is to convince you that depression and heart disease are very closely interlinked in a number of different ways. Further, it will show that they *should* be considered together whether you’re interested in reducing the health risks associated with depression or in the optimal treatment and rehabilitation of heart disease.

The Nature of the Relationship

Research evidence shows very consistently that depression is a frequent consequence after the diagnosis of heart disease. Untreated depression carries a sixfold risk for another heart attack or other cardiac problem. Given that about 30% of people with heart disease show clinically significant depression after diagnosis and initial treatment, and given that heart disease remains the number one killer in Canada, this group represents a large number of people that deserves our attention.

Interestingly, the degree of depression that people experience is not a function of how physically sick they are, but is much more a function of the person’s pre-existing personality and his or her current life circumstances. Even somebody who has relatively mild forms of heart disease can be really depressed, and this depression can worsen the disease.

In addition, there is strong evidence that pre-existing depression can contribute to the development of heart disease. One suggested mechanism linking depression to the development of heart disease is an irregular pattern of heart activity known as “suppressed variability.” Understanding this mechanism is the current topic of intensive investigation, and we are likely to learn more about depression and heart disease as we continue work in this area.

In this context, it also makes sense to introduce another term that describes a combination of feelings of low energy and fatigue, both physical and emotional. Referred to as “Vital Exhaustion,” Dutch researchers have shown that it is related to, but not the same as depression in the psychiatric sense. Vital exhaustion appears to be a frequent early warning sign (or precursor) of pending heart problems.

One also needs to consider that depression may not just have a direct effect on heart disease, but that it could affect other behaviours that will either help or hinder treatment and rehabilitation. There is overwhelming evidence that lack of physical fitness, smoking, and poor eating habits are all significant

risk factors for heart disease. Dramatic lifestyle changes, in turn, can decrease the risk of mortality or recurrent heart problems, or even lead to mild reversal of heart disease itself. However, anybody who has tried to make such changes — to quit smoking, to start and maintain a regular exercise program, and shift from unhealthy eating to relatively low-fat, low-sugar, and high-fibre diets — knows how much determination is needed to make them last. Depression, not surprisingly, robs people of the motivation and ability to make such changes. The worst thing depressed cardiac patients can do to themselves is to refuse participation in a cardiac rehabilitation program because they feel too depressed. Our own research at St. Paul’s Hospital has shown that even without formal therapy for depression, depressed cardiac patients who actively participate in an exercise program also show major reductions in depression.

How do you Recognize Depression in People Who Also Have Heart Problems?

Depression should not be seen as an “all-or-nothing” phenomenon like pregnancy, where one either is or isn’t pregnant. Instead, depression needs to be seen as a variation on a continuous scale of mood that can range from being not at all depressed to being severely depressed. Of course, the occasional brief period of low mood is a frequent occurrence in well-adjusted individuals and should not be confused with depression. It is therefore necessary to carefully monitor changes in mood that may have occurred over time and test oneself — or seek professional help — to determine whether there have been major losses of interest in eating, work, relationships and hobbies, especially if they extend over long periods. In the case of heart disease, there is the additional problem that individuals who’ve had a myocardial infarction (heart attack) are inherently weak and possess low energy levels. It’s easy to confuse this relatively normal, hopefully transient, physical effect of the heart attack itself with actual depression.

Does Treatment Work?

On this topic, there is reason to be optimistic. Numerous studies of pharmacological and psychological treatments for depression, alone and in combination, have shown that depression is very much treatable, with success rates of around 80%. New classes of drugs — in particular the Selective Serotonin Reuptake Inhibitors — have relatively few and mild side effects, are very effective, and can be taken over a long time without fear of creating addiction. Psychological therapy, in particular cognitive behavioural therapy (CBT), has also been shown to be effective, typically as effective as the best drugs. The improvements due to drug treatment tend to be very quick, whereas it takes longer with psychological therapy. However, there is evidence that psychological therapies have better long-term effects than drugs because they also

Wolfgang
Linden

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Professor of
Psychology at
the University
of British
Columbia.



give a sense of empowerment back to depressed individuals. Especially in the case of severe depression, a combination of medication and psychological therapy may be more potent than either one alone.

To date, the studies of drug treatment for depressed cardiac patients show an equally good response rate, compared to other depressed patients. In terms of psychological therapies, research is still in its early stages but the initial work suggests that CBT for depression in cardiac patients is again just as effective as it is in depressed patients overall. One concern that people like me have — note that I am a clinical psychologist — is that individuals may have difficulty accessing this option. Antidepressants are easily available through family physicians and cardiologists, where costs are covered by the Medical Services Plan. CBT, on the other hand, is an option most likely provided by clinical psychologists, which is not routinely covered by insurance carriers. At no extra cost, peo-

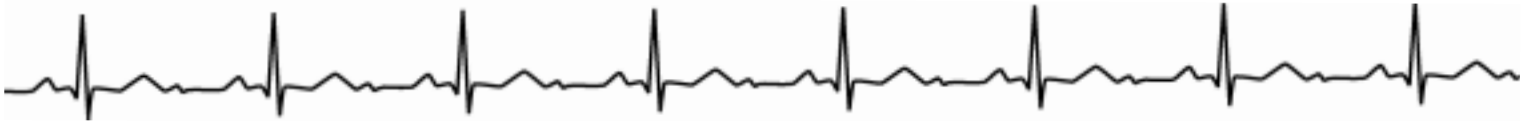
ple can take advantage of psychological services provided within general hospitals. Some may be fortunate to have an extended health benefit plan that covers psychological services outside of the hospital. However, there still remains an access problem for individuals in more remote geographical areas and/or those without good health benefits packages.

One way of reducing the problem of access is through the use of self-help manuals which are available in low-cost paperback formats, and there have been a number of studies showing considerable benefit. An additional option is to use materials now available through the internet. ■

Relevant Resources

Burns, David. *The Feeling Good Handbook*. NY: Plenum Books.

For a collection of up-to-date scientific papers, see: *Journal of Psychosomatic Research*, Special Issue, April/May 2000, Volume 48.



Lest We Forget About Lifestyle:

Neurotransmitters Respond to More Than Medication

Sarah Hamid

When I was in the throes of a severe episode of depression in 1996/97, one of the first things I realized, and what I tried to convey to people when I started getting better was this simple fact: mood disorders affect *everything*. They affected what I ate, how I dressed, how much and how well I slept, what I wrote poetry about, what music I listened to, who I hung out with, how I saw the world. In fact, the precise reason depression can sometimes feel like a nauseating merry-go-round or a ditch you can't get climb out of is because all these things that are affected by mood disorders, in turn, affect mood.

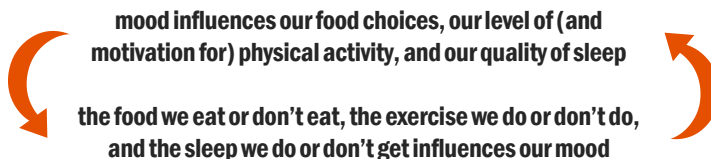
So if I chose to wear black and ugly clothes because I was feeling down, it's a safe bet to say I felt black, ugly, and down that day. Now that's not to say that if I had worn a yellow sunshiney sweater that the veil of depression would have lifted, but life with depression can be a series of self-fulfilling prophecies, where someone feels blah and so does blah things, and doing blah things helps to fuel and maintain feelings of blahness. In short, lifestyle choices like nutrition, sleep, and exercise become *both symptom and cause* of mood disorders. What you should be doing is exactly what you don't feel like doing because of your illness. Unfair? Maybe, but at least there is power in knowing day-to-day strategies that can help.

Food

Food usually makes us feel good. Anyone who has been upset and cuddled up with a box of cookies knows full well that mood influences what food choices we make. Every mood from anger, jubilation, or even just boredom can trigger poor eating choices and/or overeating. People with eating disorders like compulsive overeating or bulimia often binge on food as solace because the food pushes back the bad feelings and can temporarily make pain go away. People with depression can similarly experience a change in appetite, either eating more than usual or else not feeling hungry and skipping meals. Drastic changes in weight (in either direction) usually alter one's appearance and also further contribute to a deepening of depression.

Certain foods we eat can also influence depression. For example, consider the following:

- proteins (e.g., as found in meat, fish, eggs, nuts) contain more of a compound called tyrosine which makes us more alert, more mentally energetic, and generally more "up"
- carbohydrates (as found in pastas, potatoes, breads/cereals) contain more of a chemical called tryptophan and so when eaten alone make us feel less stressed, less anxious, more focused, and relaxed
- contrary to social hype, alcohol is not a stimulant but a depressant and so is clearly counterproductive to alleviating symptoms of depression. Unfortunately, still too many people turn to the bottle for self-medication





- there are clear connections between mood and foods rich in folates (green leafy vegetables). For instance, folate deficiency can be associated with depressive symptoms. Low folate levels have also been associated with poor response to treatment (and vice-versa)
- new studies report that eating fish (which contain “omega-3 fatty acids”) at least once a week or taking omega-3 fatty acids as a supplement are a deterrent to depression and manic depression
- drinking water is thought to replenish the cells in both the body and the brain.

Exercise

As the fitness boom hit North America in the '80s and '90s, science backed up the hype by not only demonstrating the benefits exercise provides for physical health, but for mental health as well. Numerous studies have shown that aerobic exercise three times a week can be just as effective as drug therapy for relieving symptoms of depression in the short term. In September 2000, Duke University researchers went further and showed that continued exercise greatly reduced the chances of depression returning (8% relapse rate) — *better* than the drug-only group (38%) and the exercise-plus-drug group (31%). For more on this study, go to www.eurekalert.org/releases/dumc-oe091400.html

Exercise helps treat depression in six ways:

- it releases endorphins, the body's own morphine-like, mood-elevating, pain-relieving chemicals
- it increases levels of serotonin
- it reduces levels of the stress-depression hormone, cortisol, in the blood
- it helps clear the head and provide perspective on life
- it provides a feeling of accomplishment and purpose, which enhances self-esteem
- for some exercises, it can return a depressed person to certain social networks.

For mild depression, exercise alone can often do the trick in alleviating symptoms. For moderate to severe depression, exercise alone is rarely enough; that said, exercise is a great addition to any treatment program of medication and/or psychotherapy and can often help kick recovery closer to 100%. Yes, depression is a poor motivator, but fear of relapse can be a great motivator. Even with my medication at a constant, if a week goes by that I don't get a chance to do something aerobic several times, I begin to feel worse. Exercise makes me feel good. For those of you who suffer from depression, just pick something you like to do and do it: walking the dog, gardening, playing beach volleyball — whatever! For the first month, just do it as if you're taking medicine (it takes about a month for mood-elevating effects to kick in). Thereafter, if you've picked a fun activity, you'll keep doing it because you like it

and because your body tells you that it needs it.

Sleep

Studies estimate that about 80% of depressed individuals have sleep problems as a result of their illness. Many of these problems may be associated with depression or depression medications (always ask your doctor what your antidepressant side effects are). The spectrum of possible sleep problems include:

- difficulty falling asleep
- waking up in the middle of the night and having difficulty getting back to sleep
- waking up too early in the morning
- waking up too late in the morning and feeling like napping throughout the day
- unusually brief periods of REM sleep (“rapid eye movement” or dream sleep)
- unusually long periods of light sleep (stage 1 sleep)
 - unusually brief periods of deep, restorative sleep (stage 3 and 4 sleep)
 - links to suicidal behaviour (e.g., see Agargun M.Y., Kara H., Solmaz M. (1997). “Sleep disturbances and suicidal behaviour in patients with major depression.” *Journal of Clinical Psychiatry*, 58(6): 249-51.)

According to an article in Medscape, 85% of people with depression report insomnia (can't sleep) and 10 to 15% complain of hypersomnia (sleep too much). People with seasonal affective disorder are also more likely to report the latter: sleeping too much during winter. On the other hand, people going through episodes of mania may sleep 2 to 4 hours per night for weeks, even though they say they feel rested. Changes in sleep patterns can also spell trouble. Sudden bouts of insomnia can increase risks of relapse for major depression, and even one night of sleep

deprivation for people with manic depression can spur on a manic episode in a person previously in the depressive phase of their illness.

Once you find the right treatment for your depression, problems with sleep — like other symptoms — should start to clear up. In the meantime, help the process along by maintaining a regular sleep-wake pattern, not napping during the day, not eating a large meal or exercising too late into the evening, limiting caffeine consumption, and keeping a log of sleep habits so you can track your sleep disturbances with changes in medication or lifestyle. Be sure to tell your doctor about any major changes to your sleep pattern.

Stress

I could not end this discussion of lifestyle influences on depression without at least briefly touching on the issue of stress. Stress not only directly affects depressive symptoms (stress ▶





Depression and Stress:

Recent Stressful Events are the Most Powerful Risk Factor for an Episode of Major Depression

John
McManamy

Stress: it's there in the environment, from any minor annoyance to an event likely to precipitate a flight-or-flight response, to the kind of violation that imprints the mind with severe trauma. It's also there in our biology in the form of hormones that play a key role in mediating our response to the outside world. These hormones also act as middlemen in a host of co-occurring illnesses.

Reprinted from "McMan's Depression and Bipolar Weekly," an electronic newsletter found at www.suite101.com/cfm/depression

Each day, we are learning ever more on the relationship between stress and depression, and although there is a lot we still do not know, the presence of stress as a major role-player in the disease



process is now considered beyond dispute, with therapies increasingly geared toward neutralizing its vast destructive powers. According to the Surgeon General in his landmark *Report on Mental Health*: "The compelling impact of past parental

neglect, physical and sexual abuse, and other forms of maltreatment on both adult emotional well-being and brain function is now firmly established for depression."

A study of rhesus monkeys separated from their mothers found higher levels of the stress hormone cortisol, as well as ACTH (adrenocorticotropic hormone), and lower cerebrospinal fluid levels of noradrenaline (a brain chemical which affects mood). Twenty per cent of the infants from the same study also reacted negatively to brief separations from their mothers.

ACTH is a hormone that is part of a biological chain of events beginning when the neuropeptide CRF (corticotropin-releasing factor) is produced by the hypothalamus, which activates the pituitary gland to increase the release of ACTH, which then induces the adrenal gland to release more cortisol. Medical researchers refer to the centre of this activity as the hypothalamic-pituitary-adrenocortical (HPA) axis.

Laboratory animals injected

with CRF were found to exhibit symptoms of depression, from weight loss to decreased sexual activity. CRF is found in higher concentrations in the cerebrospinal fluid of depressed patients, who also have greater numbers of CRF neurons. CRF is also found in areas of the brain and appears to be hyper-secreted during depression.

In a just-published Emory University study, four groups of women were subjected to the stressful experience of speaking and performing math tests in front of an audience, then blood samples were taken and heart rates measured. The researchers found that the women with a history of childhood abuse and current major depression exhibited a more than six-fold greater ACTH response to stress than those in the control groups.

According to the authors of the study: "Severe stress early in life is associated with persistent sensitization of the pituitary-adrenal and autonomic stress response, which, in turn, is likely related to an increased risk for adulthood psychopathological conditions." (In other words, higher levels of stress early in life make people more sensitive to stress later on, and therefore put them at increased likelihood for developing depression or another mental disorder.)

The findings also indicate that just as stress is likely to be a factor in causing depression, depression can also

Lest we forget about lifestyle (cont'd)

hormones interact with our nervous systems and neurotransmitter activity) but also has an indirect impact on depression. "Feeling stressed" affects — guess what? — our eating, exercise, and sleeping habits. And the vicious cycle starts again...

But if you make better food choices (like calming carbohydrates), release muscle tension and anxiety with exercise, and try to get at least 8 hours of sleep, you may just help yourself feel less stressed. As someone once said, "stress is not a *thing* but what you *feel about the thing*." This is why to some people, a move to a different city is an exciting adventure and to others is a panic attack waiting to happen. It's all about perspective.

One of the best things about depression — yes, there is a *best thing* — is that when you begin to recover (and you will), you will have a new perspective on life that hopefully stays with you. Depression forces you to look at big things and survive. When you leave that gray bubble, all the things that people around you obsess and stress over begin to seem so petty. You were trying to get through the week and your girlfriends are bickering about which boy they like, or your parents are arguing about whose turn it is to do the dishes. Recover, but don't ever forget the lessons depression can teach you because those lessons in self-preservation, patience, and perspective are the greatest lifestyle impacts there are. ■



bring on stress.

Situational occurrences such as marriage breakup or bereavement also loom large. A study of major depression in twins found that recent stressful events were the most powerful risk factor for an episode of major depression. According to the study, those with the lowest genetic risk of depression had only a 0.5% probability of depression that month, but this shot up to 6.2% with exposure to severe stress. Those with the highest genetic risk faced a 1.1% probability that skyrocketed to 14.6% when stress was present.

The HPA axis is working overtime during these stressful situations, and new studies are beginning to suggest two areas of the brain responsible for kicking this axis into action. The hippocampus and the amygdala are two key regulatory centres located in the cerebral areas of the brain, governing memory storage and emotions, respectively. Both are major nuclei of the limbic system, which underlies emotions. According to the Surgeon General's Report: "Sensory information enters the lateral amygdala, from which processed information is passed to the central nucleus, the major output nucleus of the amygdala. The central nucleus projects, in turn, to multiple brain systems involved in the physiologic and behavioural responses to fear. Projections to different regions of the hypothalamus activate the sympathetic nervous system and induce the release of stress hormones."

Two Centers for Disease Control studies recently examined stress on large populations. The studies looked at the effects of armed conflict

on groups of Albanians and Serbians, and represent the first of their kind by virtue of being conducted in the midst of war (or very soon after), in the region where the conflict occurred. In both studies, survivors were given psychiatric evaluations.

In the first study, two-thirds of the Albanians surveyed reported being deprived of food and water, being in a combat situation, and being close to death. More than half had been forced to flee their homes and nearly 40% had experienced at least eight specific traumatic events, from the murder of a family member to rape.

Not surprisingly, the researchers found a high rate of psychiatric disorder amongst the survivors. What surprised them was how high this figure was — 43%, twice their expectations. Adopting less conservative criteria raised the incidence to 83.5%.

A study of the Serbian population remaining in Kosovo also surprised researchers, as the findings virtually matched those of the Albanians. Apparently, war in all its terrible horror pays no regard to which group suffers the most. It's simply enough that stress hormones flood into the system like refugees streaming across the border. The stress hormones, of course, are too dumb to know that the war in Kosovo is the cause of their migration into the bloodstream. Any war will do, as will any situation approximating war. In this regard, we all represent a population at risk.

Those hormones, it seems, have plenty of places to go — the heart, the pancreas, the bones, and so on. Depression has been linked to illnesses

poetry



**I found my brain in the centre of a planet,
Lying on a beach.
"Choose a brain" they said,
So I looked and found it.
It's still tripping out,
So I cleaned it,
Told it of its compounds,
Broke it open and
Went speeding straight through the universe,
Star bases, planets, asteroids, dead space,
and
all kinds of spooky creatures,
Just trying to adjust.**

— Ken Hansen
Consumer (Sechelt, BC)

from heart disease to diabetes to stroke to bone loss to cancer. (*Editor's Note: see article on page 24 for more*). Scientists have yet to uncover the pathway from a neurotransmitter shutdown in the brain to a tumour or insulin dysregulation elsewhere in the body, but stress is invariably fingered as the likely messenger.

Fortunately, our brain circuits are not permanently welded into place. Our thought patterns can be changed and cognitive therapy is especially useful in restructuring how we perceive and react to stressful situations. With a bit of practice, "It's the end of the world!" can be altered to "Let's find a solution."

Our lifestyle choices play an essential role in nipping stress in the bud. A diet of mood-buster foods is simply tempting fate, as is irregular sleep, lack of exercise, and

putting off things until the last minute. Ultimately, you may have to lower your expectations — from what you demand of yourself to how clean you want your house to be.

One final piece of good news is scientists are developing and testing a "CRF antagonist," believed to be a decade from market. For those 20 to 30% of the population who don't respond well to antidepressants, a drug that attacks stress might do the trick.

In the meantime, though, it pays to manage your stress as if your life depended upon the outcome — which, as we are finding more and more every day, it does. ■

Related Resource

For the Surgeon General's Report on Mental Health as it relates to depression and stress, see www.surgeongeneral.gov/library/mentalhealth/chapter4/sec3_1.html#etiology



In this section, we examine the relationship between mood disorders and the world of work, considering the impact that each has on the other. For some, becoming unable to cope at work is the “defining moment” when the illness announces its presence. It is not surprising, then, that the eventual return to work, with the appropriate supports, is often a vital component of a person’s recovery. Despite its importance, obstacles abound which make it harder for people to get back, and stay, within the world of work. Helping people overcome these barriers is increasingly being seen as a key task for our mental health support programs. We’re also beginning to understand that mental illness may not always be a detriment with respect to work, and that people with mood disorders and other mental illnesses, in fact, may be over-represented in fields of creative endeavour. As a society, we need to see people with mental illnesses as positive, productive members of the work force, regardless of how “work” is defined.

My Incredible Voyage into Madness – and Back

Scott Simmie

The following excerpt describes the author’s initial experiences with manic depression and his relationship with his employer, the Canadian Broadcasting Corporation, when his illness came to a head while he was producer for the CBC’s Moscow Bureau.



The crunch came in May, during the completion of the Victory in Europe celebrations...The finale of the celebrations was to be a major parade in Moscow, followed by a summit between Boris Yeltsin and Bill Clinton...

Scott is a journalist with the Toronto Star.

This is how it happened. In January, 1995 — after working roughly 50 days straight — our crew went to Chechnya to cover the war. Covering any serious conflict can certainly not be described as fun. But proximity to danger carries with it a certain adrenaline...

On the final night, after writing the final script of the summit, I snapped. I blew up at our Russian editor — not entirely without cause — and the correspondent who had hired her. There was certainly no violence or threat of violence. And I did yell. And that’s not like me.

Excerpted with permission from *Out of Mind: An Investigation into Mental Health*, published by the Atkinson Foundation. This was Scott Simmie’s special report based on research he did while holding the 1998 Atkinson Fellowship in Public Policy.

We filed powerful stories back to Canada. I returned to Moscow exhausted. Exhausted, dirty, but fine. Sometime after that war zone experience, though, and a stressful trip home which followed it, something began to change. I began, quite simply, to feel better than normal. Significantly better...

The correspondent phoned senior managers back in Canada. I was telephoned from Toronto a day later and told I was barred from the CBC’s Moscow office pending an investigation. ... Two managers, on the phone from Toronto, shared only its conclusion: “Your position has been terminated,” I was told. There was no mention of my mental health, no mention of my job performance, not even any mention of “the incident” ...

In terms of my ability to work, things were fine. I could still write scripts, book satellite feeds, plan coverage — all the things a producer is supposed to do. But I was also more talkative than usual, more animated. I started chatting about business ideas, some of them slightly grandiose, with colleagues. I was starting to feel powerful...

I was in shock. I had worked very hard for the CBC over the years; my career was a huge part of my life. This was a crisis...

I sent notes, of which I am not proud, to management. ... A manager, who detected something amiss from afar, suggested I leave Moscow and return to a position in Canada. The notion seemed inconceivable. I was feeling, by this point, exceptional. He agreed to retain me in the post, subject to quarterly reviews of my performance. I was, in effect, on probation, and despite this scrape with management, feeling great.

Scott Simmie’s new book, *The Last Taboo: A Survival Guide to Mental Health Care in Canada*, will be released by McClelland & Stewart in January 2001. It is written as a guide both for consumer/survivors and family members to navigating our “systems” — including lots of really good advice from people who’ve been there. It will be available in hardcover at \$32.99. The book has been endorsed by CMHA National and the Mood Disorders Association of Canada. ■



next issue is on “Spirituality and Mental Health.” If you have a story idea and/or would like to contribute an article, please contact Eric Macnaughton at (604) 688-3234 or toll-free at 1-800-555-8222.



Returning to Work

Robert
Winram

Recovery's benchmark: "Are you working?" "What do you do?" How I dreaded those questions — along with "Where have you been?" After a mood disorder episode, especially if it involved hospitalization, I felt my isolation acutely. People could understand my social withdrawal, but there was no explanation for not working. Aside from the financial considerations, for reasons of self-esteem I would be desperate to be working again at the first opportunity. At work, I would be able to tell myself I was back on track, that in fact I had made a complete "recovery." I would be able to dismiss or diminish the seriousness of my need for hospitalization.

The very moment that I was out of hospital, I would push myself to be at work again. Often, I returned to work at the first possible moment, only to face a relapse. Eventually, I learned to prepare myself slowly before setting out to work. For example, I would clean my apartment, hang pictures, maximizing in every way the pleasantness of my living space. I would carefully put my clothing in order, not buy new things, just polish shoes, attend to sewing repairs, wash and iron everything that I owned. I'd clean my car. This process might take several weeks, but at the end, I would be surrounded with a sense of order that helped me combat the illness. Then I would undertake small jobs for family and friends. I had to be careful here, because I had such a need to regain my self-esteem, I would quickly take on too many projects.

My position at work was usually held for me so I did not need to face the interview process. It takes a great deal of courage to prepare for a job interview in the best of times. When recovering from depression or manic depression, with confidence at a low ebb, a job interview can be a formula for re-hospitalization. There was one time when my potential employer wanted to visit me in hospital. I said no, it wasn't necessary and I delayed his requests that I begin work, until I was certain I could both look and be effective. I had just one chance to make a first impression, so I avoided contact with him other than by phone until I was sure of myself.

Presently, we are fortunate that there are societies that help prepare a person for "the interview." For example, in Vancouver, PACT (at (604) 877-0033) helps with this, as well as with the preparation of a resume. To develop skills, there are job training organizations such as THEO ((604) 873-1758).

One question that sometimes appears on job applications is "have you been hospitalized or do you suffer from a nervous disorder?" Each individual needs to decide how to answer, but usually people answer no. Then, when they have the job and prove themselves to be invaluable and the environment seems to be supportive, often people will confide in their supervisor. However, this can be risky. Competitiveness in the marketplace means some people will use any means to overtake their fellow employees.

My memory was not good

when I was coming out of depression; I did make more mistakes. In an office setting where people knew of my illness, if a file went missing, they would say "Robert must have the file. Where did you put it?" I tried to offset this by making an extra effort at work. I would arrive early and leave late, and be very flexible regarding break times. When people asked how I felt, I learned to say "great," rather than list off all the ways my life was not working. I tried to keep my requests for special accommodation to a minimum.

Back in the '60s and '70s, I was particularly secretive about my condition. One of the ways that strategy rebounded on me was at Junior Chamber of Commerce, where everyone went to give blood. I couldn't go because I was taking so many medications. I was accused of being selfish and undermining the group's bid for perfect attendance.

I was in sales and once needed to make a boardroom presentation to new owners who had flown in from Europe. As I started the presentation, I began to perspire heavily. I was wearing a blue dress shirt that soon began to show the wetness. Rivers of perspiration flowed down my face. I had no handkerchief. I got the sale — but at what cost? One mistake I frequently made was that I wouldn't give myself enough time to drive to the client. I'd arrive a few minutes late and breathless.

There was a situation I once faced, where I had just been released from hospital and I needed to call on a woman who was particularly gra-

acious. She insisted on beginning the meeting by serving tea. When I saw the teacup, I froze; I knew my hand tremour was so bad I wouldn't be able to pick up the cup. I used both hands and rattled the cup back to the saucer a couple of times. It's hard to inspire confidence if you can't even manage a teacup.

It was difficult to restart work after each hospitalization. I was afraid that I'd forgotten everything, but once I was on my feet and talking, I'd remember, and my confidence did return. At work, some people were very kind and

“It's hard to inspire confidence if you can't even manage a teacup.”



considerate towards me. Years ago, when I was struggling to complete a number of forms, one of my competitors seemed to understand and helped me with the paperwork right in the customer's office. Only a few weeks ago, I met her at a mental health planning meeting. Now in a new career, she confided to me that she suffered from manic depression. My story is one just one of many. ■

Related Resource

See: www.ilo.org/public/english/employment/skills/targets/disability/publ/index.htm#UnpRep
There are two international studies dealing with mental health and workplace issues.



Supported Competitive Employment

David Wells

CMHA BC Division has been selected to host a province-wide initiative to address the need for supported competitive employment opportunities for the mental health community. This will be a three-year initiative that will address the current state of supported competitive employment through three primary means: education and information dissemination, addressing government policy and regulations, and building increased capacity throughout the province.

David is Provincial Director of Supported Employment at CMHA BC Division.

“Education and information dissemination” includes professional standards training and certification in psychosocial rehabilitation to professionals and service providers, mental health awareness education to the community, the creation of a dynamic inventory of mental health resources, and channels to disseminate this research and information.

“Addressing government policy and regulations” includes establishing a definitive understanding of how the existing policies and regulations work together and working collaboratively with multiple provincial and federal ministries to design policies and regulations that encourage mental health

consumers to pursue competitive employment as an option.

“Increasing capacity through the province” includes the identification and support of several supported competitive employment programs and initiatives throughout the province, demonstrating the effectiveness of different models of service, and establishing templates that can be used in creating programs in all sizes of communities. Currently we are completing the first draft of the project plan as well as conducting an environmental scan of all employment-related programs and services that exist for mental health consumers in BC.

The success of this initiative will be measured through the increased levels of service and effectiveness of those services throughout the province, as well as the numbers of mental health consumers who access those services. Success in this area will only be fully realized if we can address the barriers that exist because of government policy and regulation. Ultimately, the success of this initiative will be measured by the numbers of consumers who realize their vocational and employment goals. ■

Some Facts About Work and Mental Illness

- People with mental illness are far less likely to find work than other disabled people.
- In Canada in 1991, 48% of people with disabilities were working and 8% were actively seeking work, whereas 90% of non-disabled people in the labour force group were working. In the US, 85% of people with serious mental illness are unemployed.
- According to the 1981 Canada Health Survey, 26.4% of people with mental disorders were working, 11.8% were inactive due to mental disorder and 13.8% were inactive due to other reasons. This contrasts with people with other health problems, of whom 41.4% were working.
- Work for people with mental illness tends to be sporadic, poorly paid, and lacking employee benefits.

A LARGE “HIDDEN” SEGMENT OF THE WORKFORCE HAS MENTAL ILLNESS

- A major Canadian insurer reported a fourfold rise in claims related to psychiatric disability over a four year period.
- A western long-term disability plan sponsor with a white-collar workforce reported that close to 50% of long-term disability claims are psychiatric in nature.
- Mind, the Mental Health Charity in England, surveyed people with a mental illness who were working: 52% said they had concealed their psychiatric histories for fear of losing their jobs.
- Ontario research has estimated that 8% of respondents in the workforce with a mental health problem experience two or more months a year of decreased productivity. Unlike people with a physical health problem who tend to take time off, those with mental health problems go to work but require greater effort to function.
- The Canadian Health Survey in 1981 found that 2.9% of people who list work as their “Main Activity” have a mental disorder. These workers represent 5.2% of people who work and have at least one health problem.

STIGMA AND LACK OF AWARENESS ARE MAIN REASONS WHY CONSUMERS ARE LESS LIKELY TO FIND WORK

- 30% of employers are uncertain how to create supportive environments.
- A 1995 poll of 300 CEO’s in Fortune 500 companies found that 16% thought that hiring people with disabilities had a negative impact at work.
- A US survey found that employers viewed those with mental health disabilities with more discomfort than other types of employees. Employers who had experience with workers with mental health disabilities were more likely to hire such workers.
- A survey of employers in Britain found that the obstacles to employing disabled people were mainly a lack of understanding about the capability of disabled people, lack of knowledge about financial and technical assistance, and undifferentiated approaches to access and accommodation.
- A US report states that 43% of federal employers and 22% of private employers cited negative attitudes of supervisors and co-workers toward people with disabilities as a continuing barrier to employment and advancement.

WORK HAS TREMENDOUS BENEFITS FOR PEOPLE WITH MENTAL ILLNESS AND FOR HEALTH CARE COSTS

- People with mental illness *do* want to work and are very capable of employment that requires intelligence and creativity.
- People with serious mental illness report that they use hospital and crisis services less when they are working than they did when they were not working.
- People with mental illness who work have reduced frequency, duration, and intensity of their symptoms.
- A study of people with severe, persistent mental illness found that those who were working reported that work provided a distraction from the symptoms of their illness and contributed to better mental health.

Sidebar courtesy of CMHA Ontario Division. For the source of any or all of these statistics, please contact Sarah at CMHA BC Division (1-800-555-8222 or shamid@cmha-bc.org)



Swing Low [A LIFE]

by Miriam Toews

Miriam Toews is a highly skilled, intuitive young Canadian writer who happens to have a window into her late father's soul. *Swing Low* is that window. Adopting the voice of her father as he recounts his life, Miriam invites us to learn more about what mental illness really is when we can see it in the context of a touching and accomplished human life.

Swing Low is an incredibly moving piece of creative biography disguising itself as an autobiography. It chronicles the life of the author's father, Melvin Toews, in his own words as imagined by his youngest daughter. We learn in the first few pages of the book that Mel was diagnosed at seventeen with manic depression (bipolar disorder) and took his own life at sixty-two. The reader meets Mel in Bethesda Hospital in his hometown of Steinbach, Manitoba where he spends seventeen days in

the psychiatric ward before deciding to end his life. During that span of time, Mel has a plan to regain an understanding of what is happening to him; after all, he says, "I'm a methodical man so this business re: losing my mind is frustrating." His plan, and Miriam's as well, is to "gradually sneak up on my brain by remembering the past and then by seamlessly tying it into the present." And so Mel writes. In writing, he recounts the trips and triumphs of his Prairie life, dipping every now and then back into the present. The story he tells is wonderfully woven with anecdote, vivid portraits of members of the Toews family, witty dialogue, and lots of humour.

You don't read *Swing Low* thinking about suicide or about manic depression. You read it just thinking about Mel, about life, about its joys and its vulnerabilities, about how little we can really know about what is happening in-

side someone else's mind, even someone as close to us as a parent.

Even though Mel's manic depression is not always 'front and centre,' some of the most poignant episodes in the book are when he becomes acutely self-aware of his condition. As a much-loved teacher at Elmdale Elementary for over forty years, he wishes for control in his mental health like he had in his classroom: "I like to imagine that the teacher has left the room inside my brain and every last neuron is out of its seat and acting up. I will walk in and ask them to take their seats, and miraculously they will." Mel seems to miraculously shoe-horn his manic episodes into the 9-3 school day. Teaching is his life and purpose. He is energetic, focused, passionate, and successful there. At home, he lets the mania go and his family only gets to see his quiet depression. Miriam remembers one entire year he didn't speak at all. Needless

to say she and her sister didn't recognize their father when they became pupils in his class. Who was this man? Mel's suicide would come not too long after his retirement from this life of teaching.

Though Mel certainly comes to life in the pages of *Swing Low*, the prologue reminds us that it is also a journey his daughter is undertaking to better understand his life and the cause of his death. She concludes that despite speculation, "there's really only one answer [to his suicide] and that is depression. A clinical, profoundly inadequate word for deep despair." The only better description of depression — the kind of depression that can even lead a religious family man like Mel to suicide — is one Mel offers us himself near the end of the book: "There are no windows within the dark house of depression through which to see others, only mirrors," says Mel. And broken mirrors can be dangerous. ■

Review by Sarah Hamid



Stoddart, 2000; 191 pp.; \$27.95

Touched with Fire: Manic Depressive Illness and the Artistic Temperament

by Kay Redfield Jamison

First published in 1993, *Touched with Fire* is an authoritative — albeit fragmented — look at the relationship between manic-depressive illness and artistic inspiration. Piecing together clinical studies, biographic notes, family histories, quotes and anecdotes, Kay Redfield Jamison advances a strong case for linking the two temperaments.

Jamison, professor of psychiatry at The Johns Hopkins University School of Medicine, stresses that not every writer, painter or composer

is depressed, suicidal, or manic. "It is, rather, that a greatly disproportionate number of them are; that the manic-depressive and artistic temperaments are, in many ways, overlapping ones; and that the two temperaments are causally related to one another." Jamison is also careful not to romanticize the topic, emphasizing that manic-depressive artists expend a terrible amount of energy dealing with the illness's cycles, not simply riding them in inspired fury or melancholic bliss. Included is a detailed chapter on By-

ron, shorter sections on Tennyson, Melville, Coleridge, Woolfe, Hemingway, Van Gogh, and quotes — both literary and personal — from dozens of other prominent artists who lived with bipolar illness. Jamison correlates seasonal variations in artistic productivity with the onset or remission of the illness and also illuminates the long family history of mental illness in many of the artists studied.

Finally, *Touched with Fire* deals with the issues surrounding treatment, both on an individual basis (the ef-

fects of lithium and other drugs on artistic output) and at a societal level (genetics).

This will appeal to anyone interested in bipolar disorder, and art buffs, particularly the literary crowd (regardless of familiarity with mental illness). And a note to those with more than a casual interest: many of the study sample sizes presented by Jamison are necessarily small and some methodology is, as she admits, far from ideal. There are also likely to be more current statistics available since the last edition was put out in 1996. ■

Review by Chris Balma



The Free Press, 1993; 358 pp.

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Chris is a writer and graduate student in Vancouver.



Channeling into Creativity:

April Porter's Search for Answers

The delivery room nurse handed the squalling, squirming baby to Aileen Porter. "You're going to have trouble with this one," she said. ...

She remembers starting school when they lived at Willow Flats ("population 13") near Chetwynd, BC. ... The home movies show the kids running and jumping and playing, always in motion. ... The movies also show April's seventh birthday party. Amidst the clowning and laughing and fun, she suddenly felt awful — not sick, but scared, confused, and angry. "It was just too much for me," she recalls. She started hitting her head. But, she says, "I learned to push those feelings down." ... In Grade 9, living in Prince Rupert, she "discovered boys and booze." She was outgoing, to say the least. "What saved me in high school," she says, "was drama and music and my family supporting me in them."

They moved back to the Vancouver area, where April started suffering from migraine headaches and deep depression. "I would stay up all night," she remembers. "I had a fear of dying in my sleep." She was scared a lot of the time. "I had," she says, "no language with which to communicate. All I knew was that I was scared. But I'd had a good childhood in a loving family; I asked myself: What right do I have to feel upset?"

Her mother, April remembers, "felt helpless and powerless." Aileen Porter wrote to a friend, saying, "There's something wrong with April and she can't get help." "I doctor-shopped," April says now. One doctor bawled her out; another prescribed anti-depressants. ... In her later high school years, very much into drama and music, she used both drugs and alcohol.

At 18, April left home and enrolled in an English course at Douglas College. She made it through two semesters but fell apart — "just lost it" — during the third. ... She got into the world of rock-and-roll, working behind the scenes, organizing and promoting bands for concerts and nightclub appearances, and working in theatre and special events. Those kinds of jobs suited her two ways: it was episodic work she could do when she was up and take a break from when she was down,

and the street drugs that made her feel better — at least numb — were readily available. ... Throughout it all, April never stopped looking for a diagnosis. She was, at various times, told she had an eating disorder, OCD (obsessive-compulsive disorder), or that she was spoiled and just wasn't trying hard enough.

Her twenties and half of her thirties passed in a kind of blur. "I'd gone everywhere I could," she says, "taken a series of medications, but nothing really seemed to help." Finally, at 37, after more than 20 years of torment, she ended up at St. Paul's Hospital. She was diagnosed: rapid-cycling bipolar II disorder. "My diagnosis was not a death sentence," she says now, "but a gift. Finally, the monster had a name."...

Since June 1993, April Porter has been clean and sober. In 1995, channeling her creative side into works of art, she joined Gallery Gachet, the artists' cooperative funded as an agency of the Vancouver Community Mental Health Services. She has displayed her work at the gallery, served as a volunteer, started working part-time in 1996, and is now employed there full-time as promotions director. (*Editor's Note: April has recently accepted a position with CMHA Vancouver-Burnaby branch developing consumer-run business initiatives.*) "It's my second family," April says, "a place where I can express myself artistically and put my administration skills to good use." She had her first solo exhibition in 1998.

She works hard as an advocate for people with mental illness, serving on committees, helping others get access to services, giving advice. ... April considers that her continued recovery depends in part on giving back to the community. Which she does, and then some. At Gallery Gachet, she organizes and publicizes not only the shows, but workshops and other events featuring expert guests discussing a variety of topics from stretch massage to anger management...

April credits her "very supportive family and the world's best girlfriends" for the turnaround in her own life. And they, no doubt, credit her. ■

Excerpted from *Heroes Next Door* by Gerald Haslam.

Heroes Next Door profiles nominees of the first annual Courage to Come Back Awards. You can order the book for \$19.95 by contacting the Coast Foundation Society. You can phone them at (604) 872-3502; write them at 293 East 11th Ave., Vancouver, BC, V5T 2C4; or order the book online at www.coastfoundation.com

Tattooing the World with Desire:

Depression, Disillusionment, and the Psychology of Commerce

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Bill Pope

I've had bouts of depression since I was a teen, but it was the grinding responsibilities of adult living that caused me to feel more and

more out of touch with the natural order.

I worked for some years in advertising, doing artwork.

The pressures involved in making a living for someone else — by marketing, packaging, advertising — got heavy. All the universe be-

comes commodity. You can't fight demographics. God (or the devil) is in the details, and money drives the machine.



My small family is extended now to the mental health community, by whom I feel proud to be accepted.

Being an alcoholic is a bigger stigma to me than having depression. Learning to do things sober is a struggle and some of the pieces seem lost. My old friends who knew me when I drank just thought of me as morose, and some can't understand that many depressives drink to elevate their mood, vainly searching for a self-treatment for their sadness.

I still feel low from time to time, but signs of life are with me everywhere. Having a strong faith helped me. So has admitting others into my life to help me be objective and not treat myself so harshly. Taking professional cours-

es in self-esteem, drug and alcohol courses offered by the city, and attending AA (Alcoholics Anonymous) have all aided my recovery. Being active in volunteering helps me feel useful and makes me want to work smarter.

I still get angry at the pompous media, but being away from it helped me to develop a perspective. A sense of humour helps. There is life after tattooing the world with desire. I draw, paint, and write for myself now, so I'm putting my own brand on y'all, bar none. I hope to show some drawings somewhere, sometime, but am not pressurizing things by setting deadlines and predicting outcomes. My will is to be around long enough to be heard and seen. A few years ago, I wouldn't have thought so. ■

Bill is an artist and consumer living in Vancouver. He has provided numerous pieces of artwork for use in Visions including the one on this page and on the cover.

Applying a price to every natural act is what modern societies do, with our system of economics. Realizing this, I began to feel there was no will to give. Also there was, and is, constant pressure on me as a depressive to "do something," so that any normal act of commerce is a question of self-worth as well as self-esteem. "Will you have fries with that?" becomes burdensome when, if I say no, I might be considered a negative person. The psychology of commerce brought out a mean streak in me.

I became inwardly angry and abused by the way the marketing machine sought to corral me and magnify my inadequacies. Symbols and signs abound to the depressive. At work, every time I had to meet a deadline, the unreal ad art — detailed melodrama with a hidden hook — hammered me down. I began to loathe myself because I

was the jerk branding stuff on to people. "Joe's Butterfly Repair" had to have their flyers. I would drink to make myself numb enough to work.

When my numbness caused me to lose my family, I despaired at being so stupid as to be trapped by loathsome half-lies. The truth was I was trying to deny my mental illness and deny that my drinking had become a problem. I almost died trying to cover it up.

I was helped by going to the emergency ward and being properly and respectfully diagnosed by a doctor right there. I spent some time in the hospital and haven't had a drink in nine years. I'm also being treated for essential hypertension. The depressive cynic in me would say: "Now what are the odds of that happening?" but it happened, and for the sake of those that love me, I'm happy that it did.

Performance Pieces Raise Awareness of Mental Illness

I have been heartened to discover recently that creative works are being performed in BC which bring attention to mental health issues.

Barbara Bawlf

A dance piece called *ICE: beyond cool* was performed September 20th to honour the life of a young student, Josh Platzer, who committed suicide one year ago. The performance was held at Point Grey Secondary School and was by invitation to the school community only. The next performance of the dance drama took place in Ottawa, which kicked off a national tour finishing in Prince George on November 6th. Five performances were held October 25-28th at Vancouver's International Village near Yaletown.

ICE was developed from a series of workshops that were done over a period of three years with more than 250 teenagers. Vancouver DanceArts director Judith Marcuse and Headlines Theatre director David Diamond produced and facilitated the workshops, which developed into a piece featuring a 15-



member cast of actors and dancers. There is a talkback session at the end of each performance where the issues surrounding suicide and depression are discussed among performers and audience.

In Delta, an exciting project showcasing the writing of Tsawassen resident, Maureen Haggerty is underway. Maureen is a person who first encountered mental health difficulties in her teens, but was undiagnosed while in high school. She has written about those experiences in the form of a play which, with the help of co-writer, John Hedgecock is to be produced in Delta in February of 2001. A committee called Promo Productions is working to get the production off the ground, and funding has been obtained from the South Fraser Health Region through a Health Innovations Promotion grant that will assist in covering costs. The play will be performed in four high schools in the Delta area with a view towards reaching not only teenage students, but increasing public awareness of mental illness as well. ■



Madness, Masks and Miracles

After her last bout of clinical depression last year, June Swadron began to collaborate with actors and writers who live with a mood disorder to write a play incorporating some of their experiences. Out of this collaboration has evolved *Madness, Masks and Miracles*, a play created to raise awareness and give hope to individuals living with mood disorders. Their families, friends, mental health professionals, corporate employees, government workers, students and the public at large will benefit from this project.

“The title of my play,” says Swadron, “is about the madness or insanity we all have from time to time, the masks that we are forced to wear, lest we be seen as crazy and ostracized for it, and the miracles that finally allow us to remove the masks once and for all.”

Swadron, creator of *Madness, Masks and Miracles* is a psychotherapist, certified life skills coach, and workshop facilitator. She was first diagnosed with manic depression in 1971.

On October 17th a successfully staged reading was presented to guests who work in the health and wellness professions.

In the play, Susan Levy is a successful lawyer, suffering from clinical depression and panic attacks. When she can no longer “keep it together,” her hopelessness takes over. She attempts suicide and wakes up in the psychiatric ward of a large city hospital. It is here she encounters Nadine, a person with manic depression, as well as Cynthia, who currently suffers from postpartum depression. We also meet Dorothy, a wise and compassionate nurse, Susan’s law partner who car-

ries an attitude of “get over it, everyone has stress,” and Susan’s mother who is totally bewildered by it all.

Madness, Masks and Miracles is a story of hope, courage and everyday miracles. It’s the kind of stuff that goes beyond the stage, inspiring each of us to move through life with optimism, strength, and dignity. As yet, there are no male characters, but the intention is to bring at least one male into the story. All of the current actors have been touched by mood disorders: either personally or through a loved one.

When completed, many of the play’s performances will be supported with professionally facilitated workshops by experts in the field of mental, emotional, physical, and spiritual health.

Besides the horror of the physiological, emotional, and psychological characteristics of mental illness, one of the most painful aspects is the stigma associated with it. “The amount of shame and guilt that I have carried most of my life — as though I actively and purposely did something wrong — has caused me as much pain as the illness itself,” Swadron

states. “Now that I have ‘come out of the closet,’ I am in awe at the number of people who have come forward to share their own stories. When one in five people in North America suffers from clinical depression at some time or other in their lives, can we really afford to have a WE vs. THEM mentality? Of course not.”

“I thank God every day for the miracles that have come to me,” Swadron says, “and that I am alive and well once again, and can now give back some of what I have received.”

If you are an interested individual or part of an agency or corporation that would like to hire a performance of *Madness, Masks and Miracles*, or would like to have a package with the play and workshop series combined, please call June Swadron at (604) 682-5559 or Lee Clarke at Hub Productions Ltd. at (604) 681-1892. The next public reading will be at the *Porridge for the Soul* breakfast:

- Tuesday, January 2nd, 2001 at 7 am
- to be held at the Canadian Memorial Centre for Peace (1825 16th Avenue, Vancouver (near the corner of 16th and Burrard)). ■

poetry

**With all the power of gravity,
Suction and travel,
I force my way past
Limits of space and beyond
Into the future of my life,
Where things are new
And a whole lot more true
Than the average day
That I knew.**

— Ken Hansen
Consumer (Sechelt, BC)



A Path to Recovery Paved with Movies

Movie Monday started as a sparky idea from a guy recovering from a severe depression and second suicide attempt. I was becoming slightly hypomanic, part of my manic-depressive illness — the creative, optimistic side of a roller coaster emotional ride I'd been on much of my life. Finally I was on a better mood stabilizer and the right kind of support. And I was hot on a new scheme.

My wife was keen that our life get back to normal. "Look after yourself, your family, and your gardening business," she said. But I'd discovered a 100-seat lecture auditorium in the basement of Eric Martin Pavilion in Victoria with a video projector, and the idea of showing films there for patients and ex-patients had captured my imagination. When people gather for popular film entertainment, there are a lot of other cool things that can spring from that. Now, seven years later, 420 events later, my day job (landscape maintenance gardening) is thriving, as is our family, and Movie Monday is still a vital interest and creative expression for me.

Just a month out of hospital, with no funding and no long term plan, my friend Peter and I started things going. It was much to the credit of the hospital's audio-visual staff that they even considered allowing me free use of the facility. I reasoned that it would be a health-related event, but even I thought it was a bit chancy. I realized right away that the key was consistency. The entertainment had to be there regularly, so people would make it a habit and a community would build.

At first I publicized it through the hospital and my support group. When just a few people showed up, I broadened my promotion to hostels and drop-in centres downtown. The first few months, I got butterflies in my stomach every time I thought of having to be there next Monday with a show for the expectant audience. For a person with mood swings, consistency can be a scary prospect. But I was enthusiastic about movies and since it was my idea — there's nothing like ownership — I was able to make it work and pursue those goals I had imagined from the start. I treated it like my gardening business: with relentless promotion, focus, attention to detail, and thrift.

A big leap in commitment and exposure to the public was made when, hoping to raise funds for better equipment, I was featured in an article in Victoria's city paper. It was a turning point when I weighed the risk of talking about my illness publicly. It's been a very positive move for me and for my family. One of the best results of this experiment has been to shed all the baggage that comes with the usual secrecy, and to make a constructive thing of our family's challenges with mental illness. Weekly now, I see the healing effect of that openness.

Quite early on I realized films could stimulate discussion about mental illness.

When I showed *Benny & Joon*, along with a facilitated discussion, this was the first time I'd presented a popular film with a mental illness-related theme. The discussion was very wide-ranging and involved people with personal experiences of mental illness who had lots to say. This was their forum, and I learned a lot. After that, Movie Monday's schedule has always included a rich peppering of such films — which include discussion opportunities and special guests — like *One Flew Over The Cuckoo's Nest*, *Shine*, and *Curtis' Charm*. In January, we'll be presenting our third *Reel Madness Film Festival* in Victoria: five days of films and discussions about mental illness and recovery.

I also realized early that just showing up week after week, addressing the audience, consistently putting up eclectic, creative programming, talking about mental illness and health, making at least part of our psychiatric hospital a friendly approachable place — has a pervasive effect. Even though we have a small venue, the ripples of information, positive attitude, and hope travel out into our community.

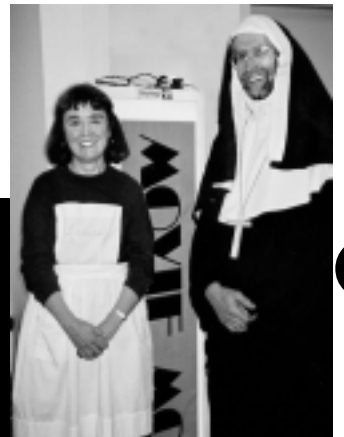
And the ripples come back to me. What I've gained is a whole other identity. Where before I felt like I was hanging on to a thin pretense for living, now I have a unique opportunity to express myself artistically and intellectually. I've learned to express myself on paper effectively and speak publicly. I have lots of reasons to interact with artists, filmmakers, and with movers and shakers in the mental health community, both peers and professionals. I've been more stable and happy than ever before. Movie Monday has given me a platform to make something good of all the losses and dreary experiences. Our family is proud of dealing well with an illness that has haunted my family of origin and could have claimed me and even my children. I feel I've turned that fate around. Last June, I celebrated a 50th birthday I never thought I'd reach. I've still got an illness that I have to manage. It's never lost on me though, walking through the hospital to set up for another event, that it's great to come back into this place each week, not as a patient, but as a provider of a service, feeling like a winner.

For more info on Movie Monday or for a schedule of *Reel Madness* events, go to www.islandnet.com/mm. ■

Bruce Saunders

Bruce lives in Victoria, BC and is the founder of Movie Monday and the Reel Madness Film Festival.

▶▶ Bruce Saunders (right) and his wife Laurel (left) in costume for Movie Monday's "Sing Along Sound of Music" which ran July 31, 00.



**General Information about Mood Disorders**

For exhaustive links to web sites about depression, see depression.miningco.com, www.depression.com, and www.psychcom.net/depression.central.html#contents. For exhaustive web sites about bipolar disorder, see bipolar.miningco.com and bipolar.about.com

Rapid-Cycling Bipolar Disorder: see www.mother.com/~andys/index.htm and www.ndmda.org/rapid.htm

“Dealing with Treatment-Resistant Depression”: this article is aimed primarily at clinicians. See www.medscape.com/Medscape/psychiatry/TreatmentUpdate/2000/tu04/public/toc-tu04.html

Depths of Despair: an excellent CBC radio documentary on mood disorders. See www.radio.cbc.ca (follow the links to “This Morning”).

Learned Optimism by Dr. Martin Seligman. Pocket Books (1998). A book on preventing depression and building optimism. For other books on depression, see www.vcn.bc.ca/rmdcmha/depression.html

Mood Disorders and Creativity

“Michael’s Depression Page” (www.geocities.com/mjattwood_nz/depression.html) lists numerous links to sites dealing with mood disorders and creativity, while **“The Reading Room”** (www.geocities.com/the_reading_room/index.html) and **“Fire and Reason”** (www.geocities.com/SoHo/Village/5990/index.html) are web sites featuring collections of creative work by consumers.

“Mood Swings and Everyday Creativity”: an article by Dr. Ruth Richards at www.mentalhealth.com/mag1p5h-md04.html

Children, Youth, and Mood Disorders

For information about childhood bipolar disorder, see www.geocities.com/EnchantedForest/1068 (a web site for families and those who care for children with bipolar disorder); see www.mentalhealth.com/mag1/1997/hp97-bp03.html (an article published by *The Harvard Mental Health Letter*); and see www.appi.org/pnews/oct4/adhd1.html (an article about the link between bipolar disorder and attention deficit disorder).

For numerous links related to mood disorders in children and youth, see www.psychom.net/depression.central.html#contents (follow the links to “Depression in Children and Adolescents”).

For articles about medication and children with depression, see www.suite101.com/article.cfm/depression/32180

For an electronic journal article devoted to prevention of depression and anxiety, see <http://journals.apa.org/prevention/>

Seniors and Depression

See the Winter 2000 edition of *Network* on Senior’s Mental Health.

Available for ordering or downloading at www.ontario.cmha.ca

See “Dealing with Depression,” the Summer 2000 issue of *Expressions*, a Health Canada magazine for seniors. Find it at www.hc-sc.gc.ca/hppb/seniors/pubs/expression/13-3/exptoce.htm

Women and Depression

For links to a number of recent articles, see www.suite101.com/welcome.cfm/women_and_depression

Study in Grey: Women Writing About Depression, edited by Wynne Edwards and Shirley Serviss. Rowan Books (2000).

“The Age of Anxiety”: a great Newsweek article on mood and anxiety disorders and gendered brain differences. Available at newsweek.washingtonpost.com/nw-srv/printed/special/wh99/ch4/wh17_1.htm

For an article on postpartum mood and anxiety disorders, see www.medscape.com/medscape/psychiatry/TreatmentUpdate/2000/tu02/tu02-04.html

Medications and Side Effects

For good web sites on medications and side effects, see:

- Internet Mental Health at www.mentalhealth.com/p30.html
- National Empowerment Society (USA) www.power2u.org
- Steven Thow’s www.mhsource.com/wb/throw9903.html (and go to topic #8: “What can I do about my drug’s side effects?”)
- Dr. E. Fuller Torrey’s Treatment Advocacy Centre and Ralph Nader’s Public Citizen at www.citizen.org/eletter/

Alternative Treatments

For general information, read CMHA BC’s overview at www.cmha-bc.org/yellowbk/newtreat.html. For information about a “supplement” known as SAM-e, go to www.suite101.com/article.cfm/depression/28543. Read an article about St. John’s Wort at www.suite101.com/article.cfm/depression/17231. For a list of links about a number of alternatives, see Steven Thow’s web page at www.mhsource.com/wb/throw9903.html (and go to topic #16: “Where can I find information about on herbs and alternative medicine and treatments?”). Also, see the web site of a research consortium studying a promising new supplement for bipolar disorder at www.truehope.com

Electroconvulsive Therapy (ECT)

For general information, see www.ect.org, www.psychcom.net/depression.central.ect.html, and for a good review article, see www.suite101.com/article.cfm/depression/23856. For information about a promising alternative to ECT known as rTMS (Repetitive Transcranial Magnetic Stimulation), see www.psychom.net/depression.central.transcranial.html