



MAJOR DEPRESSION

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FROM: *Major Depression and Bipolar Disorder: A Workbook for Patients and Families*, Brad Lyles, MD and Cheryl Rotherham, MS, LCSW

Overview of Mood Disorders:

Mood Disorders are misnamed. Though they include Major Depression and Bipolar Disorder and all of their subtypes, the Mood Disorders are NOT really disorders of mood. Instead, they are brain conditions caused by changes in brain chemistry and, at times, brain anatomy (on a microscopic scale). They are disorders of everything BUT mood, at times. They affect general body functioning, general body feelings, pain, and life functioning. How, then, can we refer to them simply as “Mood Disorders?” We can’t! Nevertheless, common usage and convention dictate that we call this class of what are essentially neurological conditions, well, Mood Disorders. Go figure.

Charlie

Charlie felt numb. He didn’t feel like himself. He thought he must have some kind of virus. He had no energy and his concentration wasn’t so good, either. He didn’t care about things. He wasn’t motivated. He was irritable. Charlie knew he had some kind of sickness. Charlie saw his family doctor about his symptoms. His family doctor reassured him and gave him an antibiotic. Charlie got worse. His work began to suffer. His supervisor asked him if everything was OK. Charlie said that of course it was. Charlie began to feel sad about things. He cried easily. He went back to his doctor. His doctor diagnosed depression (Major Depression). His doctor put Charlie on an antidepressant. Charlie got better at first, but several weeks after starting the antidepressant, Charlie began to feel worse. He got more agitated. His moods seemed to vary, one day OK, the next day irritable and sad. Charlie went back to his family physician. He was given a higher dose of medication. He became even more irritable. He became suicidal. Charlie shot himself.

Review of Charlie’s story:

Charlie’s story is not so far-fetched as it might sound. Charlie’s story is a story played out nearly 30,000 times per year in the U.S. It is the story of a mood disorder leading to suicide. In particular, though, Charlie’s story is something else. It is the story of the current likelihood that depression and bipolar disorder will be misdiagnosed. It is the story of how this needn’t be the case. It is the story of hope among hopelessness.

Charlie’s physician could have diagnosed Major Depression at his first visit, thus saving Charlie the continued pain he suffered until the next visit. However, Charlie’s physician didn’t know what depression looked like. Since Charlie wasn’t “depressed” at the first visit, the physician presumed (wrongly) that Charlie wasn’t depressed (depression is not required for a diagnosis of Major Depression – more later). Charlie’s physician could have noticed that Charlie began with significant agitation. Charlie’s physician could have warned Charlie that that might have been a sign of bipolar disorder and to watch out for “manic acceleration” or “manic overshoot.” Since the physician did not know about those two possibilities, he did not warn Charlie. Perhaps, if he were lucky, Charlie would have returned to the physician with obvious manic (bipolar) symptoms, and gotten appropriate treatment. In today’s world, this is highly unlikely, given that the average patient with bipolar disorder is misdiagnosed for 8-10 years before being correctly diagnosed. Unfortunately, Charlie’s agitation, combined with his depression and hopelessness, combined so intensely as to lead him to take his life. The sun still rose and set. The waves continued to caress the shore. The wind blew one way today, another way tomorrow. Charlie was still dead. His physician was still ignorant. Misdiagnosis continued across the land.



WORKSHEET 1:

- 1) Are Mood Disorders disorders of mood or are they really brain disorders that cause all manner of symptoms, *including* mood symptoms?
- 2) How did Charlie's story make you *feel*?
- 3) What *message(s)* can you find in Charlie's story?
- 4) What do you suppose "manic overshoot" is?

THE TOP TWO MOOD DISORDERS:

- 1) **MAJOR DEPRESSION**
- 2) **BIPOLAR DISORDER**

As you likely already know, Major Depression and Bipolar Disorder are the top two Mood Disorders, tops in terms of frequency (numbers of those effected) and tops in terms of disabling negative impact caused by Mood Disorders. Thus, our Workbook will focus primarily on how one can best know about and cope with these two disorders. If one is able to do that, one will also be able to better cope with their less severe cousins.

THE TOP TWO PROBLEMS IN MOOD DISORDERS:

The top two problems that loved ones and sufferers of mood disorders face is **late or misdiagnosis**, and **late or suboptimal treatment**. If these two scourges of the mood disorder universe could be defeated, almost all of the current unnecessary suffering due to mood disorders would end. If only these two things were destroyed. Only these two things.

- 1) **LATE DIAGNOSIS OR MISDIAGNOSIS**

A mess-up with diagnosis is the first REALLY BIG PROBLEM you should know about mood disorders. As noted above, late diagnosis is usually the result of misdiagnosis. Many physicians end up running expensive test batteries (and finding nothing) to evaluate for the symptoms of Major Depression. This will be easy to understand later when we review the symptoms of Major Depression. You see, Major Depression symptoms are mostly everything BUT depression. In fact, one can suffer Major Depression WITHOUT being depressed. The symptoms of Major Depression, in fact, are more like a combination of Chronic Fatigue Syndrome and Alzheimer's Disease – physical and mental symptoms – but often, no depression. At this point, you're probably wondering what all this means. What it means is that things are rarely what they seem. What it means is that Major Depression is the great imitator (of physical conditions). What it means is that physicians often "miss" Major Depression and therapists often "miss" Major Depression. Physicians often believe they're seeing a thyroid problem and therapists believe they're seeing unresolved intrapsychic conflict. The depression is therefore, of course, misdiagnosed. Time passes. The depression is finally diagnosed, but too late. Destruction to families, to friends, to jobs, and of course, to the patient themselves, has already run amuck in their lives. Regrets and sorrow are the reward.

Late diagnosis (rather than misdiagnosis) is largely due to something else besides ignorance on the part of providers. Late diagnosis is most often due to the fact that less than one-half to two-thirds of people seek evaluation. Instead, they suffer quietly, losing jobs, spouses, lives. Because Major Depression is the Great Imitator, no one sees it until it's too late, if at all. No one's friends or family sees it. No one's co-workers or bosses see it. Instead, they see a person who has a problem, who IS a problem. They withdraw. They fire. They divorce. You can't diagnose it if you can't see it. If people don't go to see their doctor, their doctor can't see what they might be suffering. Of course, therefore, their doctor can't do anything to help.

- 2) **LATE OR SUBOPTIMAL TREATMENT:**

Late or suboptimal treatment is the Second Really Big Problem about mood disorders that you most need to know. Given that the best in treatment depends upon the best in diagnosis, one can hardly fault a provider if they haven't even had a chance to diagnose a person (say, for instance, if that person



never shows up in their office, or anyone's office). The first task, therefore, in ensuring good treatment is to ensure an accurate diagnosis. First, this means that we have to work to somehow persuade the two-thirds of the population that avoids diagnosis to come in and get some. Second, it means that we have to have some reliable means by which to diagnose people once they do come to the office (We do. It's called the DSM-IV). Third, this means we must start with clinicians who have some idea that there IS a DSM-IV, and some idea of how to use it. Fourthly, it means that we must employ clinicians who have some idea about the Really Big Things to Know about Mood Disorders, including the fact that Major Depression is the Great Imitator.

Once we have established an accurate diagnosis, things get to be really complicated. (Keep in mind that two-thirds of people don't even get this far, and two-thirds of the people who do, don't get diagnosed accurately – recall that it takes 8-10 years for a person with bipolar disorder to be so diagnosed). The reason things get complicated is because there are so many competing theories about what is right and what is not in the treatment of mood disorders. Let's look at several examples of what happens.

FAMILY PHYSICIAN EXAMPLE:

A family physician will diagnose depression. He may shirk his duties and refer the patient to a therapist, a therapist who does not recognize the severity of the depression and does not refer for medication management. Perhaps a family physician prescribes an antidepressant. He/she will usually prescribe an inadequate dose. Suppose the inadequate dose fails to work. The family physician will often, then, switch out the antidepressant, failing to do that which a trained clinician (a psychiatrist) would do, (which often involves adding two or more medicines together for "augmentation" effects). Suppose the patient gets worse, becomes more agitated. Will the family physician recognize the brewing MANIC ACCELERATION or MANIC OVERSHOOT? Will the family physician recognize that the diagnosis has changed to Bipolar Disorder?

THERAPIST EXAMPLE:

A therapist meets a patient who suffers Major Depression. The therapist utilizes COGNITIVE-BEHAVIORAL THERAPY for the patient (one of two research-supported therapies). Three months pass. The patient is not appreciably improved. The therapist realizes that therapy alone is not working for the patient and refers the patient to a psychiatrist for medication evaluation. Three months have passed. Three months of the patient's life have remained in the toilet. What if, however, the therapist refers to the primary care physician? What then? What then is that we have the same problems we saw above in the example with the primary care physician.

REALLY BIG THINGS ABOUT MOOD DISORDERS:

The **REALLY BIG THINGS** to know about the Mood Disorders are that: 1) You need to seek the best in diagnosis to get the best in treatment (and this is very hard to do), and 2) You need to seek the best in treatment to get the best in diagnosis (and this is also very hard to do). These two things are the natural conclusions of the two **REALLY BIG PROBLEMS** noted above.

MAJOR DEPRESSION AND BIPOLAR DISORDER

Bipolar and Unipolar concept

Many people wonder why Bipolar Disorder is so-named and why it became the new, official name for Manic-Depressive Illness, in 1980. First, it helps to know that "Unipolar Depression" is a term synonymous with Major Depression. It follows that Bipolar (having two poles) would become the name for Manic-Depressive illness. In short, the term, Bipolar Disorder, appears to have been adopted since the advent of the DSM-III (the diagnostic manual of the American Psychiatric Association) primarily because no one had ever heard of Bipolar Disorder – thus, it was a term that was less stigmatized. By 1980, "Manic-Depressive" was a term both stigmatized and misused. The funny thing is, of course, that "Bipolar" has never really caught on. One way to demonstrate this is that every time one uses the term Bipolar Disorder, one has to quickly point out that one is referring to "Manic Depressive Illness." Only then do heads nod in understanding.



WORKSHEET 2:

- 1) What are the top two Mood Disorders?
- 2) What are the top two *problems* in the Mood Disorders?
- 3) What are the first two *really big things to know* about the Mood Disorders? (Hint: They follow from the top two *problems* in the Mood Disorders).
- 4) Why is Bipolar Disorder called *Bipolar* Disorder?
- 5) Think about your own experience(s) with misdiagnosis or under-treatment. What did the clinician *miss*? What did the clinician *fail to do*? How much time did you or your loved one lose? How many years passed before the initial diagnosis?

THE THIRD REALLY BIG THING TO KNOW ABOUT MOOD DISORDERS – THE BIOLOGICAL BASIS OF MOOD DISORDERS:

Biological Nature of Major Depression and Bipolar Disorder:

The THIRD REALLY BIG THING, THE THIRD MOST IMPORTANT THING TO KNOW about Mood Disorders is that they are BIOLOGICAL in nature. Specifically, the current research unequivocally demonstrates that Major Depression and Bipolar Disorder are BRAIN DISORDERS, based upon changes in BRAIN ANATOMY AND BRAIN CHEMISTRY. Later, the brain basis of the Mood Disorders will be explored in detail.

The fact of the biological nature of the Mood Disorders leads to the GRAND PARADOX: Mood Disorders are not really disorders of “mood.” Instead, they are everything but. Mood Disorders are disorders of energy, concentration, appetite, sleep, poor stress tolerance, racing thoughts, agitation, etc. They are NOT primarily disorders of MOOD. This fact cannot be hammered home enough. You will see more of it later. Keep in mind, though, if you are looking for a horse but you think it looks like a chicken, you aren’t likely to find many horses. So it is with the Mood Disorders. If you are looking for Depression or Mania, you aren’t likely to find them if you think they look like chickens (or, rather, if you think they look like Depression or Mania). So there it is. The Mood Disorders do NOT look like chickens! The Mood Disorders, instead, look like everything else but a Mood Disorder. Keep this in mind when you’re trying to help yourself understand the TRUE NATURE of the Mood Disorders, when you’re trying to figure out how to spot one in yourself or in a loved one. Don’t look for chickens! Look, instead, for all of the “body” signs and symptoms of the Mood Disorders. Therein the truth doth lie.

THE FOURTH REALLY BIG THING TO KNOW ABOUT MOOD DISORDERS:

The patient and family should be educated in all aspects of Major Depression and Bipolar Disorder and how best to manage them.

Of course, this isn’t fair. It’s just the way that it is. You may have predicted it, though, based upon all of the ignorance we’ve covered previously. The rule, caveat emptor (buyer beware) applies in spades in the area of the diagnosis and treatment of mental disorders.

A REVIEW OF THE FOUR REALLY BIG THINGS TO KNOW:

- 1) **REALLY BIG THING TO KNOW #1: You need to seek the best in diagnosis to get the best in treatment (and this is very hard to do).**
- 2) **REALLY BIG THING TO KNOW #2: You need to seek the best in treatment to get the best in treatment (and this is also very hard to do).**
- 3) **REALLY BIG THING TO KNOW #3: The nature of mental disorders is biological.**
- 4) **REALLY BIG THING TO KNOW #4: The most important aspect of treatment is education, what the patient and family know.**



OTHER REALLY BIG THINGS TO KNOW ABOUT MOOD DISORDERS:

Although the four “Really Big Things to Know” about mood disorders are the really big things to know, there are a number of other Really Big Things to Know that would be good to know, as follows:

- 5) Misdiagnosis and underdiagnosis is the rule, not the exception, with Mood Disorders.
- 6) Undertreatment or poor treatment is the rule, not the exception, with Mood Disorders.
- 7) Major Depression and Bipolar Disorder are biological, and thus clearly “no-fault” illness
- 8) The patient is therefore powerless to “directly” “pull themselves out of it.”
- 9) Major Depression and Bipolar Disorder are markedly disabling for *everyone* who suffers with them, and that’s why they’re so disabled, (not because of “weakness” on their part),
- 10) That “checkers” (loved ones or friends) are crucial.
- 11) That medication is a necessary evil
- 12) That medicine must be used in the type and amount that’s best for each individual.
- 13) That this sometimes involves repeated experiments with different medications
- 14) That the cyclic nature of Major Depression and Bipolar Disorders means that patients will obtain relief no matter what, either with the right medication or via egress of the Mood Disorder.
- 15) That psychotherapeutic exploration of deeper psychological issues (such as past trauma or abuse), is usually unhelpful until the biological Major Depression or Bipolar Disorder is resolved.

SUBTYPES OF MOOD DISORDERS:

There are many different subtypes and varying features of the most disorders. The most prominent subtypes are those that follow:

1. Major Depression: This is the most common, (10.3% of U.S. population), most prevalent, and most commonly disabling mood disorder. It requires two weeks or more of depressive symptoms.
2. Dysthymia (chronic minor depression): This effects about half the number of those with Major Depression. It requires a two-year duration of depressive symptoms.
3. Depressive Disorder, NOS: Includes disorders with features of Major Depression that do not meet criteria for any specific depressive disorder.
4. Bipolar Disorder, Type I: Bipolar Disorder, Type I, effects 1% of the population. It requires a history of at least one manic episode. A manic episode requires one week or more of symptoms of mania (see below). Bipolar Disorder is the sixth most common cause of disability worldwide.
5. Bipolar Disorder, Type II: Bipolar Disorder, Type II, effects an estimated 1-3% of the population, though estimates vary widely. Bipolar Disorder, Type II, requires that a person suffer symptoms of mania *that are not quite as severe as those of Type I*, and are present for 4 or more days.
6. Bipolar Disorder, Mixed: Bipolar Disorder, Mixed, manifests an unclear prevalence. It requires a history of BOTH a Manic AND Depressive episode concurrently, within the same one week (or more) period.
7. Cyclothymia: Cyclothymia effects approximately 1% of the population. It is defined by the presence, for at least two years, of repeated hypomanic episodes in association with depressive symptoms not meeting criteria for Major Depression or Bipolar Disorder.
8. Bipolar Disorder, NOS: The Bipolar Disorder NOS category includes disorders with bipolar features that do not meet criteria for any specific bipolar disorder. Thought to account for up to 3-8% of the population. Part of what is referred to as the “Bipolar Spectrum” of disorders, including Bipolar Types I and II, and Cyclothymia. This diagnosis, in real life, is often used as a “temporary” diagnosis while the clinician is waiting for more definitive diagnostic information to reveal itself.



Worksheet 3:

INSTRUCTIONS: Please fill in or choose the best answer for each question. Answers are found in the Appendix of Answers in the back of the book. Please complete the Quiz, since it reviews the material that came just before and will reinforce your learning on this topic. Please feel free to go back to the original material to find the answers.

A) The **FIRST FOUR REALLY BIG THINGS TO KNOW** about Mood Disorders include:

- 1.
- 2.
- 3.
- 4.

B) The two primary disorders included under the category of Mood Disorders are:

- 1.
- 2.

C) The Nature of Mood Disorders is:

D) The most common problems with diagnosis include:

- 1.
- 2.

E) The most common problems with treatment include:

- 1.
- 2.

F) The subtypes of Mood Disorders include

- 1.
- 2.
- 3.
- 4.
- 5.

Mary

Mary, a 31 year old nurse, married, began to feel unwell. She suffered flagging energy, decreased interest in usual activities, significant weight loss, insomnia, decreased sex drive, irritability, and decreased concentration and memory. She was also depressed. Surprisingly (she was a nurse), she did not recognize that she suffered biological Major Depression. In fact, she thought she suffered from some type of thyroid problem or chronic fatigue syndrome. For the most part, she blamed herself and thought she was simply failing to “buck up.” Mary got contrary. She felt worse. Her husband noticed her agitation and low energy. Though she couldn’t sleep at night, she slept most of the rest of the day when she wasn’t at work. Her husband (not knowing about Major Depression, of course) blamed Mary, asking her repeatedly, “what’s wrong?” Mary responded repeatedly, “I don’t know.” Finally, when at her worst, Mary’s supervisor at the hospital gave her a written warning because of her deteriorating work quality. This was the last straw. Mary couldn’t get out of bed for three consecutive days. Mary’s husband finally demanded that she see the doctor. Mary saw her primary care physician. End of story? No. The primary care physician undertreated Mary. He used the lowest dose of an otherwise effective antidepressant. When Mary returned to this physician, having suffered 6 more weeks, the physician switched the low-dose of the original antidepressant to a low-dose of a second antidepressant. This, too, was ineffective. Mary, considering herself a treatment failure, failed to return for her third appointment.

REVIEW OF MARY:

Mary’s vignette demonstrates several key considerations in the diagnosis and treatment of Major Depression. Unlike in Charlie’s case, discussed above, Mary DID receive a correct diagnosis the first time out of the gate. Her primary care physician DID do the right thing, sort of. However, Mary’s primary physician didn’t do ENOUGH of the right thing. He didn’t prescribe a therapeutic dose of the first antidepressant for Mary. Because of this, the medicine did NOT work. Mary was therefore



compelled to wait another 4-8 weeks for the doctor to determine that his first treatment failed. Not being familiar with the optimal dosing of antidepressants (but thinking he was), the primary care physician then failed to increase the dose of the first antidepressant. Instead, he CHANGED antidepressants, again using a suboptimal (too small) dose. By Mary's appointment, four weeks later, she felt no better. She did not return, instead continuing to suffer. When her husband asked her to return, again, to the doctor, Mary retorted that, "I already tried that and it didn't do any good. This is just the way I am. Get used to it!" Now, two things could have saved Mary. First, if her family physician had referred her concurrently to a therapist (a knowledgeable therapist) from the very first, the therapist would have been present in the situation and able to help Mary through her resistance to treatment. There was no therapist. Thus, there was no help. The family physician could also have referred Mary to a psychiatrist, (if she would go – many people would rather gnaw off their left arm). The psychiatrist would hopefully (would at least have a higher likelihood) use a therapeutic (right) dose of an antidepressant, and Mary would therefore get better in a few weeks (how long it takes for the right medicine at the right dose to work). Case closed. If only.

In conclusion, "Mary" demonstrates the violation of the second "Really Big Thing to Know: "You need to seek the best in treatment to get the best in treatment." The "best in treatment" usually involves the specialist in the field. Thus, when it comes to treating the most disabling medical condition in the world (Major Depression), one would not be considered too irresponsible if one consulted a specialist in that condition (a psychiatrist) from the very first go. If only.

Worksheet 4:

- 1) How did Mary's story make you *feel*?
- 2) What did Mary's story make you *think*?
- 3) What could Mary have done to change the outcome of her situation?
- 4) Is there anything in Mary's story that reminds you of your own experience?

OVERVIEW OF MAJOR DEPRESSION:

We will now review, specifically, the scourge of Major Depression. Major Depression is the leading cause of disability in the WORLD! At least it is according to the World Health Organization, (WHO). The WHO, along with Harvard University, conducted what is known as the "Global Burden of Disease Study." This study assessed the degree of disability caused by ALL major diseases, including cancer, heart disease, etc. Not only did Major Depression come out number one, but four out of ten of the top causes of disability, worldwide, were found to be due to mental disorders.

It is critical to know about Major Depression's disability rank in the world because its rank means several things. One, Major Depression is a legitimate, life-sapping, disabling, illness, hands down. Being such, it's clearly not due to some problem with subnormal character or lack of willpower. It's not even due to depression, as we'll find out in just a moment. Two, Major Depression deserves all of the public advocacy and awareness now reserved for high blood pressure and heart disease. Except for a few nationally broadcast commercials by Mike Wallace (who talks about his own depression), there's nothing much in the media today that accurately depicts depression or the need to get treatment for it. In fact, the current situation is so bad that lives are lost, and for no reason. Suicide is currently the 11th most common cause of death in the U.S. – about 30,000 deaths per year. Most suicide victims suffer from Major Depression. Most people with depression (one-half to two-thirds) do NOT receive treatment, much less diagnosis, for their depression. Instead, they die. They lose families. They lose jobs. And all of it unnecessary. Depressions is almost completely treatable in 80-90% of cases. What are we waiting for?! We have to spread the word! We must spread the word! (Well, you don't have to, but if you can, it would be a good thing – a courageous thing – a good thing).

Knowing that Major Depression is the number one medical cause of disability in the world, and knowing that Major Depression causes, among other things, about 30,000 deaths per year in the U.S., and knowing that Major Depression is not really depression (more later), it would be helpful to know how many Americans suffer from Major Depression. Answer: 9% within any one year period and 17% within their lifetimes. Major Depression is twice as common in women than in men. Now,



knowing all of this, the only conclusion possible is that Major Depression is a serious medical condition, a biological disorder, effecting brain chemistry and brain anatomy (for real) that should be taken as seriously as any disorder so characterized, and should cease being blamed on its victims. In fact, it is this latter conclusion that is so clear and convincing when one knows the FACTS. How, for gosh sakes, could we ever again blame someone for suffering from Major Depression? Do we blame cancer victims? Do we blame heart attack victims? Do we blame stroke victims? No, (unless, of course, they were smokers), but no, not really. Do we blame those with biological Major Depression for having depression? You betcha! (Well, you probably don't, but you would agree that most of the population does, despite those excellent Mike Wallace commercials. You now know the frequency of Major Depression (9% of the population of 300 million in the U.S.), and you know that it's the number one disabling disorder in the world (yes, we are being redundant here) and that it's really treatable, and that most people with it don't get treatment, and that it kills nearly 30,000 Americans per year (through suicide – it's still dead). Now, it's time to review the boring (but important) stuff about the underlying symptoms of Major Depression. When you've done that, you'll understand one of the most important facts about Major Depression: It's not usually depressed!

DSM-IV-TR CRITERIA SYMPTOMS:

The DSM-IV-TR (The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision) presents the actual, "worldwide" standard criteria for the Mood Disorders. We will later review the formal comprehensive criteria (just in case you wanted to know). However, for now, we will review the DSM-IV-TR criteria informally. This will hopefully allow you to obtain a feeling – in your gut – for what each of the Mood Disorders involves.

DSM-IV-TR INFORMAL CRITERIA SYMPTOMS:

Primary Symptoms:

- 1) Depressed mood
- 2) Decreased interest or pleasure in almost all activities (The name for this symptom is "anhedonia.")
- 3) (For children: Irritable mood counts as depressed mood)

Secondary Symptoms:

MOOD SYMPTOMS:

- 1) Depressed mood
- 2) Feelings of worthlessness or excessive guilt
- 3) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

PHYSICAL SYMPTOMS or NON-MOOD SYMPTOMS:

- 4) Decreased interest or pleasure
- 5) Diminished ability to think or concentrate, or indecisiveness
- 6) Weight loss or weight gain
- 7) Decrease or increase in appetite
- 8) Insomnia or hypersomnia
- 9) Psychomotor agitation or retardation (slowed down)
- 10) Fatigue or loss of energy

TWO WEEK PERIOD:

The above symptoms must be present for two weeks or more (for Major Depression). Of course, this is a silly requirement since anything even approximating Major Depression (i.e. anything that manifests the symptoms noted above), almost always lasts far longer than two weeks. In fact, two months or two years would be far more likely. Two weeks it is, though, according to the DSM-IV-TR.

SIGNIFICANT DISTRESS OR IMPAIRMENT:

In order "to count," the symptoms above must cause clinically significant distress or impairment in some area of life. Of course, "significant" is not defined or operationalized, but is left to the imagine of the diagnostician. Fortunately, most rationale people would agree upon what "significant" means when applied to the symptoms of Major Depression. It's sort of like the infamous judge who uttered, "I can't define pornography, but I know it when I see it."



PHYSICAL VERSUS PSYCHOLOGICAL NATURE OF MAJOR DEPRESSIVE SYMPTOMS:

It is especially important to recognize that there are MORE non-mood or physical symptoms (7) than there are mood symptoms (3) found among the diagnostic criteria for Major Depression (or rather, a Major Depressive Episode). Awareness of this fact is critical to ever understanding Major Depression. Understanding of this fact leads one to the understanding that for the most part, Major Depression is NOT “depressed.” It IS, however, everything else. It is change in appetite, change in weight, poor concentration, agitation, decreased interest or pleasure in usual activities (anhedonia), insomnia or hypersomnia (too much sleep), body agitation or body slowing down, fatigue or loss of energy. Notice that nowhere in there did we mention depression or a sad mood. This whole “biological perspective” of Major Depression has lead Professor JM Kanner to muse that Major Depression is NOT a psychiatric disorder at all, but is a neurological disorder with psychiatric complications. Brain chemistry and brain anatomy studies of Major Depression would tend to agree with Dr. Kanner. The take-home message here is that if you have a loved one who suffers depression, or if you suffer yourself, keep in mind ALWAYS that you (or your loved one) suffer from a physical disorder of the brain that has far more to do with brain chemistry than with your mood, and is far more disabling (number one in the world) than either heart disease or cancer.

ASSOCIATED SYMPTOMS OF MAJOR DEPRESSION:

As with all things in life, the Mood Disorders are more complicated than the DSM-IV-TR would imply. For starters, there are a number of depressive and bipolar symptoms that are commonly associated with the diagnoses of the mood disorders. One cannot use these symptoms to “formally” diagnose the disorders. Nevertheless, one should remain vigilant about these additional symptoms since they are clues to the diagnosis:

Discouraged about the future or feelings of hopelessness

Feeling of being punished

Disappointment in oneself

Blaming oneself for weaknesses and mistakes and/or for everything bad that happens

Crying more than usual of not being able to cry at all

Losing interest in other people

Greater difficulty in making decisions

Feeling unattractive or ugly

Having to push oneself very hard to do anything

Worries about physical health problems

Decreased interest in sex

Early morning awakening (and not being able to fall back asleep)

Not feeling rested after sleep

Feeling worse in the morning

Worksheet 5:

DEPRESSION SYMPTOM QUIZ:

OPEN BOOK QUIZ:

- A. List the three PRIMARY SYMPTOMS of Major Depression:
 - 1.
 - 2.
 - 3.
- B. List the 10 SECONDARY SYMPTOMS of Major Depression
 - 1.
 - 2.
 - 3.
 - 4.
 - 5.
 - 6.
 - 7.
 - 8.
 - 9.
 - 10.



- C. How long do symptoms of MAJOR DEPRESSION have to last before they become a MAJOR DEPRESSIVE EPISODE?
- D. What do MAJOR DEPRESSIVE symptoms have to cause in order to be considered symptoms of MAJOR DEPRESSION?
- E. Name your five favorite ASSOCIATED SYMPTOMS of Major Depression:
 - 1.
 - 2.
 - 3.
 - 4.
 - 5.

So, after going through all of the above, you're like wondering what the "REAL" symptoms of Major Depression look like. Well, they look like the following:

DSM-IV-TR CRITERIA FOR MAJOR DEPRESSIVE EPISODE

- A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
 - 1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: in children and adolescents, can be irritable mood.
 - 2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - 3. significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
 - 4. insomnia or hypersomnia nearly every day
 - 5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings or restlessness or feeling slowed down)
 - 6. fatigue or loss of energy nearly every day
 - 7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - 8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - 9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a mixed episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).
- E. The symptoms are not better accounted for by bereavement, i.e. after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

MIXED EPISODE:

The formal criteria noted above indicate, in part B., that the symptoms do not meet the criteria for a "MIXED EPISODE." What in the dickens could that be? Well, a "MIXED EPISODE" refers to the situation in which Major Depressive Symptoms co-exist with Manic Symptoms (more later). Of course, it's hard to see how Major Depressive symptoms could co-exist with Manic Symptoms, but this does happen.

Eddie:

Eddie, a 38 year old, married, successful developer, presented for evaluation to the psychiatrist (imagine!). The psychiatrist diagnosed Eddie as suffering from Major Depression. The psychiatrist noted, however, that Eddie suffered from severe agitation, apparently a component of his depression. The psychiatrist began Eddie on antidepressant medication. At first, the medication seemed



to provide significant benefit to Eddie. It improved his mood, his agitation, his energy, and his concentration. Eddie did well for about 6 weeks. Then the bottom fell out, as it were. Eddie returned to a state of even worse depression, with worse agitation. The psychiatrist worried that Eddie's depression had broken through the initially successful antidepressant. Failing to reconsider the diagnosis, the psychiatrist added another antidepressant (of a different class) to the first, and then added an augmenting (booster) agent as well. Eddie again improved, for a short while, then worsened. The psychiatrist, fearing the worst, requested the presence of Eddie's wife. Eddie's wife recounted Eddie's many misadventures, his speeding tickets, his bad business decisions, his gambling, his affair. When asked specifically, Eddie's wife also described his severe moodswings, pressured speech, and the fact that "on any given day, I don't know which Eddie I'm going to get. "We call him Dr. Jeekyll and Mr. Hyde around the house." The psychiatrist rebuked himself, silently, "How could I have missed all of this?!" (aside from the fact Eddie had minimized all that his wife had just told the doctor). The psychiatrist thus diagnosed Bipolar Disorder, Type II, (since Eddie's symptoms clearly began BEFORE he was given antidepressants, as is a diagnostic requirement), and began appropriate anti-Bipolar treatment. Within four weeks, Eddie was doing better than he ever had. The psychiatrist worked hard to get Eddie and his wife to see a therapist for all of the reasons outlined in this workbook (learning, training, practicing, changing), but they wouldn't hear of it. "Well, I hope I see him on the next cycle," mused the psychiatrist.

DISCUSSION OF EDDIE:

Eddie represents a classic case of missed Bipolar Disorder diagnosis. Unfortunately, it is the rare psychiatrist and the even rarer primary care physician who makes the diagnosis this quickly and changes treatment just as quickly. As the research conducted by the Depression and Bipolar Support Alliance has shown, the average patient with Bipolar Disorder requires 8-10 years of suffering before someone changes his/her diagnosis from Major Depression to Bipolar Disorder. It takes this long, as well, before effective treatment is begun. Eddie was lucky. Furthermore, Eddie's symptoms were so dramatic, on their own, and in response to antidepressants, that the diagnosis nearly made itself. However, it is important to point out something that the psychiatrist did that clinched the diagnosis. The psychiatrist engaged the family, i.e. the spouse, in the process of diagnosis. Doing so, he "got the goods" on Eddie, not in a critical manner, of course, but in a comprehensive information manner. The wife's information clinched the diagnosis of true Bipolar Disorder, thus, painting the short-lived antidepressant responses into sharp relief. Of course, medication treatment is only a small part of effective treatment. Psychoeducation (education about the disorder), explanation, learning, and practice, are all required to manage Bipolar Disorder effectively. The psychiatrist knew just the right therapist for Eddie and his wife. However, at this stage in their lives, Eddie and his wife did not see the need for "non-medication" therapy. Eddie, therefore, maintained his visits for medication management, but steadfastly refused to see a therapist or a "consultant" as the psychiatrist referred to the therapist.

OVERVIEW OF BIPOLAR DISORDER:

Bipolar Disorder is the sixth leading cause of disability in the world. This is pretty good for a disorder that formally affects only 1% (Type I Bipolar Disorder) of the U.S. population. Of course, from 1-8% are suspected of suffering from a bipolar spectrum disorder (including Type I, Type II, and NOS (Not Otherwise Specified)). Bipolar Disorder has been psychiatry's bugaboo for the last decade. This is because its diagnosis has been expanded to overlap monstrously with the diagnosis of Major Depression. In fact, some major researchers now believe that up to 50% of those diagnosed with Major Depression truly suffer from Bipolar Disorder, instead. There is a reason that all of this is not just a bunch of academic mumbo jumbo. The reason is that TREATMENT DEPENDS UPON DIAGNOSIS. There's even another reason: TREATMENT FOR MAJOR DEPRESSION CAN MAKE BIPOLAR WORSE! This little problem occurs when one thinks one is dealing with Major Depression and instead, one is dealing with Bipolar Disorder. One can really muck things up in such a situation. You see, antidepressants make BIPOLAR DISORDER WORSE. So it's not just a problem of missing the diagnosis and missing the right treatment, therefore. It is a problem of actually MAKING THINGS WORSE if you miss the diagnosis. Too confusing? (Don't feel bad; it was confusing to all of us the first time, too). Think about it this way. What would happen if you picked up a can of liquid, and you thought it was water, and you used it to douse the flames of a fire. That would be like treating depression with an antidepressant. What if the water, though, were gasoline. You'd make the fire explosive, right! Well that's what happens when you treat what looks like depression with an



antidepressant (when it's really bipolar disorder). You make a burning fire even hotter. You make the depressive symptoms, and associated agitation, and associated bipolar symptoms, all the more worse.

This dilemma, the missing of the bipolar disorder, and therefore the wrong (and hurtful) treatment of bipolar disorder, is the major issue capturing the attention of modern psychiatry in this decade. Premature antidepressant treatment is blamed for everything, now, from bringing out bipolar disorder at all, to bringing it out too early, to making it worse overall, to making it longer lasting, to causing world hunger, (well, not the last one). So guess what symptom characterizes most psychiatrist in this decade. Paranoia! "Oh, gosh, are we going to cause bipolar disorder; are we going to miss it; are we going to treat it with an antidepressant; are we going to stop the antidepressant too late, too early; are we going to screw things up?"

THE GRAND PARADOX: The Grand Paradox applies here as well as it does for all of the so-called "Mood Disorders," especially Major Depression. The Grand Paradox is the fact that Bipolar Disorder (Manic-Depressive Illness) is NOT, for the most part, Manic or Depressive. Instead, Bipolar Disorder is a collection of "body" signs and symptoms, "neurologically and brain-based" signs and symptoms, such as pressured speech, racing thoughts, impulsive behaviors, poor judgment, poor concentration, fatigue, increased energy, decreased need for sleep, insomnia, increased or decreased appetite, etc. etc. Yes, we're back to the chicken problem. The answer, of course, is to STOP LOOKING FOR CHICKENS! When you're trying to find Major Depression or Bipolar Disorder (Manic-Depressive Illness), stop looking for Depression or Mania! You won't find them! (At least, that's not the main stuff that you'll find). Instead, look for all of the other symptoms that go along with the "moods" of depression and mania. Only then will you have a chance of finding what you're really looking for.

INFORMAL DSM-IV-TR CRITERIA FOR A MANIC EPISODE:

(Keep in mind that for Bipolar Type I, a person must suffer at least one Manic Episode).

PRIMARY SYMPTOMS:

- 1) **Elevated, or**
- 2) **Expansive, or**
- 3) **Irritable Mood**, lasting at least 1 week

MOOD SYMPTOMS:

- 1) inflated self-esteem or grandiosity

PHYSICAL SYMPTOMS:

- 2) decreased need for sleep
- 3) more talkative than usual or pressure to keep talking
- 4) experience that thoughts are racing
- 5) distractibility
- 6) increase in goal-directed activity or psychomotor agitation
- 7) excessive involvement in pleasurable activities that have a high potential for painful consequences

LASTING AT LEAST ONE WEEK:

Note that the primary symptom(s) above must last for at least one week. Unlike the criterion of 2 weeks, for Major Depression, it is sometimes difficult to actually meet the criteria of ONE WEEK for a MANIC EPISODE. This is because most garden-variety bipolar disorder manifests much shorter-acting manic swings...measured in hours, if not days. Rarely is a manic episode measured in weeks, (though in the 1% of the population with Type I Bipolar Disorder, we do see this phenomenon a lot more often. Anyway, the ONE WEEK CRITERION FOR MANIA is therefore somewhat stricter, (since it is more rarely seen) than is the TWO WEEK CRITERION FOR MAJOR DEPRESSION.

MARKED IMPAIRMENT:

Just as with Major Depression, a Manic Episode does not count if it does not cause MARKED IMPAIRMENT. Of course, this is a subjective measure, but MARKED IMPAIRMENT is still something that most of us would agree upon if asked to point it out.

RAPID CYCLING:

You may have heard the term, "RAPID CYCLING," in the past. You probably thought that it had something to do with day to day cycling. Nope. Rapid cycling refers to Bipolar Disorder wherein there are four or more cycles per year. Yes, per YEAR. What about all of the cycling we see in ourselves or



our loved ones? Well, four or more cycles per month is referred to as ULTRA-RAPID CYCLING. Four or more episodes per week is referred to as ULTRA-ULTRA RAPID CYCLING. Of course, wouldn't you know it, but RAPID CYCLING Bipolar Disorder is far more difficult to treat than "regular" Bipolar Disorder.

Next, we will review the formal criteria for a manic episode. Recall that one needs have only one manic episode in order to be diagnosed with Bipolar Disorder Type I. We will apologize herein, however, for the seeming redundancy of placing the formal criteria right after the informal criteria. There is method to the madness, however.

Worksheet 6:

- 1) What are the three so-called *primary symptoms* of Bipolar Disorder?
- 2) What are the six so-called *physical or non-mood symptoms* of Bipolar Disorder?
- 3) What is the "*Grand Paradox*" of Bipolar Disorder (and Major Depression)?
- 4) How many *weeks* must bipolar symptoms be present in order to make the diagnosis of a manic episode?
- 5) How many *episodes* of mania or depression per year are required for the diagnosis of "*rapid-cycling*" bipolar disorder?
- 6) What kind of impairment is required in order for bipolar symptoms to qualify as a "manic episode."
- 7) Can a person suffer bipolar disorder by manifesting a solely *irritable* mood (along with the other symptoms of bipolar disorder)?

Formal DSM-IV-TR Criteria for Manic Episode:

- A. A distinct period of abnormally and persistently elevated expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
 - B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 - 8) Inflated self-esteem or grandiosity
 - 9) Decreased need for sleep (e.g. feels rested after only 3 hours of sleep)
 - 10) More talkative than usual or pressure to keep talking
 - 11) Flight of ideas or subjective experience that thoughts are racing
 - 12) Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
 - 13) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - 14) Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
 - C. The symptoms do not meet criteria for a mixed episode
 - D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
 - E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment or a general medical condition (e.g. hyperthyroidism).
- NOTE: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.



THE FAMILY:

How Major Depression and Bipolar Disorder are Family Problems

What the heck could the Mood Disorders have to do with the family?

- 1) **GENETICS:** Well, first of all, the Mood Disorders are highly inheritable. The family pedigrees of those who suffer Major Depression or Bipolar Disorder are commonly filled with relatives who suffer either one of these disorders (most commonly Major Depression), or relatives who are suspected of suffering these disorders (Aunt Edna, who had a nervous breakdown, but never got treatment).
- 2) **IMPLICATIONS OF GENETICS: A) VALIDATION:** Realizing the genetic basis to the Mood Disorders helps the sufferer understand that what they are enduring is a valid, understandable phenomenon, genetically inherited, biologically based, and NO-FAULT. For instance, the person with a Mood Disorder often feels “alone,” “defective,” “worthless.” Knowing that others in the family have gone through the same thing, and that they, themselves are not at fault for what has clearly been a genetic influence in the family history, is often quite liberating. **B) ANGER:** We don’t see this too often. However, it is not that unlikely that a sufferer will feel angry with his/her family for passing on the Mood Disorder trait. **C) GUILT:** Especially with parents, GENETIC GUILT rears its ugly head. Parents feel that if only they had not shared the genes for a Mood Disorder, then their offspring would not be so afflicted. This, of course, is where we intervene to share with the parents and the child that genes at most account for ½ of the reason someone has the disorder. The environment, the whole environment (not just how someone was raised), including prenatal infections, post-natal stresses, colds, etc., can all serve to unlock genetic potential. Thus, no one is at fault. No particular thing, even the genes, is at fault. The nature of the Mood Disorders is the same as the nature of all medical disorders. They happen. **D) OTHER FAMILY MEMBERS:** One logical conclusion of the genetic predisposition to Mood Disorders is that OTHER MEMBERS OF THE FAMILY suffer from mood disorders as well (as noted above). This means, however, that one’s siblings might also suffer. One’s parents might suffer. Imagine, if you will, what it would be like to grow up with a mother (or father) who suffered from Major Depression. For days on end, this parent would enter the DARK DAYS and would sleep all the time, become irritable, (not themselves), unresponsive, fatigued, lethargic, isolative, inattentive. The other parent would become increasingly frustrated with the depressed parent, so much so that they might even divorce them (we’ve personally worked with couples where this was the case). The children, distanced by these behaviors on the part of both spouses, would blame themselves (children always blame themselves), wondering what in the dickens they could possible have done to cause such havoc. The children would misplace their self-esteem, their confidence in adults, their comfort in close relationships. The children would become friends with denial, avoidance, projection, and dissociation. The children would be scarred, scarred by a fire burning within one of their parents, a fire that no one understands. The children would grow up to be adults... still scarred, and still carrying the genetic predisposition to a Mood Disorder. Of course, just about the time that they begin to suffer from their own Mood Disorder, they have children. Stress blows the Mood Disorder through the roof. Luckily, however, the spouse sees the Zoloft commercial on the TV. The spouse suggests that the sufferer see someone. It is done (no, it’s not. Just this part is done). In conclusion, the implication of genetics upon the family is that more than one person will likely be suffering a Mood Disorder at the same time. Thus, the sufferer(s) end up having to cope not only with the usual (unknowing) relatives, but with relatives (usually close relatives) who are unknowing but are ALSO suffering. Whoa!
- 3) **NOT IN ISOLATION:** The Mood Disorders do not exist in isolation. They exist in people. People exist with bonds to other people. Family members are not always, but are usually the most tightly bonded to the sufferer. Given this fact, and given the fact that most people have SOMEONE close to them, we can examine the nature of “Family” implications in Mood Disorders. We’ll simply skip all of the issues that regular families struggle with: Striving for identity of teens, striving for independence of young adults, return to home of divorced children, shared child care, family of origin issues, abuse, shame, guilt, resentment, bitterness, anger, etc., etc. Given all of these issues, what does a Mood Disorder bring to the mix? First, it brings a worsening, an exacerbation, to the mix. Whatever existed in the family before is now going to be turned up a notch. Whatever rivalries existed, or now going to be more heated. You get the picture. Now, of course, the person with a Mood Disorder (child, parent, sibling) is not only going to have to cope with the regular family issues (see above). That person is also going to have to cope with the enflamed issues that their Mood Disorder has engendered. Thirdly, that person is going to have to cope with all of the Mood Disorder specific reactions that his/her Mood Disorder stimulates. “Get up and get out!” “Why do you sleep all day while I have to go out and earn a



living for this household?!” What’s wrong with you?!” “When are you going to stop moping around and get up and do something?! “How come you can talk to your friends all day, but you can’t talk with us?” “When are you going to finally get better.” “You’re so crabby all the time!” “What do you mean you spent all of our savings on some magic beans?!” Mood Disorders are clearly individual disorders and they are clearly Family Disorders.

Finally, there are many things, discussed later, that the family can do to stem the tide of worsening conflict. The family can learn about the Mood Disorders. The family can learn what NOT to do, regarding mood disorders (stopping repeated confrontations would be a good start). Families can learn what TO do regarding Mood Disorders. Massive stress reduction would be a good start, here. The family, the loved ones, are CRITICAL to recovery, are CRITICAL to success!

STRESS

Holmes-Rahe Stress Scale:

In 1967, researchers, Holmes and Rahe, developed a scale of perceived stress based upon their research into stressful life conditions. They were seeking a scale that would predict the likelihood that someone would suffer a serious illness within the next two years. A score of 250 on this scale is considered high. However, a score of 150 may be even higher, depending upon a person’s ability to cope with stress. Consequently, those who suffer active Major Depression or Bipolar Disorder, (who possess virtually NO ability to tolerate stress), are at risk from even the smallest stresses on this list. The list is important, however, in that it allows a pseudo-objective measure of the AMOUNT of stress one is facing in any six month period or so, and the amount of accommodation to that stress that is needed. It goes without saying that the higher the stress, the worse the Mood Disorder.

1. Death of spouse – 100
2. Divorce – 73
3. Marital separation – 65
4. Jail term – 63
5. Death of close family – 63
6. Personal injury or illness – 53
7. Marriage – 50
8. Fired from work – 47
9. Reconciliation – 45
10. Retirement – 45
11. Change in family member's health – 44
12. Pregnancy – 40
13. Sex difficulties – 39
14. Addition to family – 39
15. Business adjustment – 39
16. Change in financial status – 38
17. Death of close friend – 37
18. Change in line of work – 36
19. Change in number of marital arguments – 35
20. Mortgage or loan over 10,000 – 31
21. Foreclosure of mortgage or loan – 30
22. Change in work responsibilities – 29
23. Son or daughter leaving home – 29
24. Trouble with in-laws – 31
25. Outstanding personal achievement – 28
26. Spouse begins or stops work – 26
27. Starting or finishing school – 26
28. Change in living conditions – 25
29. Revision of personal habits – 24
30. Trouble with boss – 23
31. Change in work hours, conditions – 20
32. Change in residence – 20
33. Change in schools – 20
34. Change in recreational habits – 19



35. Change in church activities – 19
36. Change in social activities – 18
37. Mortgage or loan under \$10,000 – 17
38. Change in sleeping habits – 16
39. Change in number of family gatherings – 15
40. Change in eating habits – 15
41. Vacation – 13
42. Christmas season – 12
43. Minor violation of the law – 11

Source: Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, 11, 213-218.

THE NATURE OF STRESS:

It is critical to understand that stress is not simply a psychological construct. It is real. It is physical. How so? First, stress (psychological or medical) causes the body to react in certain ways. Specifically, stress increases the amount of circulating cortisol, the stress hormone. This hormone in turn activates numerous other hormones in the body which activate numerous body systems. As you can imagine, stressful situations invoke fearfulness, (job loss, love loss, etc.), and aggression, (flight or fight response), which in turn activate certain body functions (increased blood pressure, increased blood flow to muscles, decreased blood flow to non-essential organs (intestines), increased vigilance of the environment, etc.). All of these changes are mediated, ultimately, by brain processes. States of chronic stress are like states of chronic pressure or tension in mechanical systems. They weaken the mechanical system. Stress weakens the body AND the brain. Stress actually causes brain DAMAGE in those areas that are continually switched on because of the chronic stress. This, in turn, damages those areas of the brain that have to do with Mood Disorder. So, from now on, think about stress in a whole new way. It's not just for breakfast anymore! Stress is a physical force, mediated by hormones, that does BRAIN DAMAGE. It rips neurons apart. It kills neurons. Stress KILLS. And in killing neurons, stress also kills 30,000 people per year (in the U.S.) via suicide. Stress makes Mood Disorders worse! Down with STRESS!

Worksheet 7:

- 1) What is the nature of *stress* in the Mood Disorders?
- 2) What is the importance of *stress* in family relations, with regard to Mood Disorders?
- 3) What are the *top 5 stresses* according to the Holmes Rahe Stress Scale?
- 4) What do *genetics* have to do with the mood disorders?
- 5) On average, how many people in the U.S. *die* by suicide each year?

THE END – THE NEVERENDING