

DEPARTMENT OF VETERANS AFFAIRS

Support And Family Education



Session Two – Depression and Bipolar Disorder and Their Impact on the Family

Materials Needed:

Handout E: [What Can I Do When My Family Member Is Depressed?](#)

Brochures on local treatment options for people dealing with depression and bipolar disorder

I. Symptoms and course of depression

- A. Everyone feels depressed or down at times; however, major depression is more than just feeling the “blues” every once in a while. Each person’s experience of depression is unique.

?

Discussion Questions:

- What are some symptoms of depression?
 - Which are most difficult for you to cope with?
1. Feeling sad, blue, or down
 2. Losing interest in previously enjoyed activities
 3. Experiencing a change in appetite or weight
 4. Having a change in sleep patterns
 5. Feeling tired and fatigued OR feeling restless
 6. Feeling worthless or guilty
 7. Having trouble concentrating, thinking, or making decisions
 8. Having thoughts of death or suicide

- B. The diagnosis of a major depressive episode is made when a person experiences five or more of these symptoms that occur nearly every day for at least 2 weeks – with at least one symptom being depressed mood or loss of pleasure in previously enjoyed activities (*DSM-IV*).
- C. Approximately 6.6% of the nation (13-14 million people) suffers from some type of depression every year (Kessler, Berglund, Demler et al., 2003). It is often called the “common cold” of mental illness. Many famous people have struggled with clinical depression, including television reporter, Mike Wallace; British prime minister, Sir Winston Churchill; Diana, Princess of Wales; comedian Drew Carey; singer/songwriter John Denver; writer Charles Dickens; singer Mariah Carey; musician Billy Joel; talk show host Oprah Winfrey; tennis star Monica Seles; comedian Chris Farley; musician Sting; and Academy-Award-winning actor, Rod Steiger.
- D. According to a large community study, the prevalence of major depression in adults is approximately 16%, making it one of the most common psychological disorders. The average duration of an episode is 16 months (Kessler et al., 2003).
- E. The lifetime incidence of major depression for women is 20% and for men is 12%. Also, people living in poverty are approximately four times more likely to suffer from chronic depression than more affluent people (Kessler et al., 2003).
- F. Depression also tends to be recurrent, as over 80% of individuals with depression experience another episode (Mueller et al, 1999), many within 1 year (Coryell et al., 1994).
- G. Often an individual with major depression also has another psychiatric disorder. For example, one large study found that almost $\frac{3}{4}$ of people with major depressive disorder also met criteria for another disorder (commonly anxiety disorders and substance-use disorders) (Kessler et al., 2003).
- H. Because of the very nature of depression (decreased concentration, decreased motivation, social withdrawal, fatigue, etc.), individuals are often less productive in the workforce. In fact, US workers with depression cost employers approximately \$44 billion per year in lost productive time (Stewart et al., 2003). Depression has been described as the leading cause of disability in the United States and many other developed countries.

II. Symptoms and course of bipolar disorder (also known as manic depression)

- A. Another kind of depression involves large mood swings in which consumers go from feeling depressed/sad to quite happy (or irritable). These mood swings are different from everyday fluctuations in mood, as everybody has their “up” and “down” days. These changes in mood are dramatic and interfere with the person’s ability to manage his/her emotions; they often affect relationships and work functioning as well.
- B. Approximately 5.7 million American adults (~2.6% of adults) in any given year have bipolar disorder (Kessler, Chiu, Demler, & Walters, 2005).
- C. People living with bipolar disorder alternate between periods of depression (symptoms listed above) and episodes of mania. Although each person’s experience of mania is different, some common symptoms (*DSM-IV*) include:
 - 1. Feeling “high” or “on top of the world” or having an “overly” good mood (Note: some people feel irritable instead of happy.)
 - 2. Needing less sleep than usual
 - 3. Being more talkative than usual and/or with pressured speech (this is often more obvious to other people than to the consumer him/herself)
 - 4. Having racing thoughts and/or jumping quickly from one topic to another
 - 5. Being easily distracted
 - 6. Demonstrating excessive productivity (e.g., cleaning the entire house, being very productive on work projects) and/or being more agitated than usual
 - 7. Pursuing risky activities that can have bad consequences (e.g., spending a lot of money, illicit sexual behavior, gambling)
- D. Men and women tend to experience bipolar disorder at approximately the same rate, and the age of onset tends to be similar (Kawa et al., 2005).
- E. Both men and women living with bipolar disorder are at increased risk for abusing alcohol and drugs (Hendrick, Altshuler, Gitlin, Delrahim, & Hammen, 2000); they are also more apt to also have anxiety disorders such as PTSD (Mueser, Goodman, Trumbetta, Rosenberg, Osher et al., 1998).
- F. A good documentary depicting bipolar disorder is: *Dark Glasses and Kaleidoscopes: Living with Manic Depression* (1997). Hosted by Tony Dow (Depression and Bipolar Support Alliance, DBSA). Available for viewing at: <http://www.depressionforums.org/forums/Dark-Glasses-Kaleidoscopes-t1039.html>

III. What causes depression

- A. No one single factor causes depression. Often it is impossible to determine one specific cause of a person's illness. The constellation of causes is unique to each individual.
- B. Family members and friends need to remember that depression is not a person's fault.
- C. Several causes are common:
 1. Certain life events may trigger a depressive episode (e.g., death of loved one, retirement).
 2. A strong genetic factor is present in many cases of depression and bipolar disorder.
 - If one identical twin has major depression, the other twin has an approximately 37% chance of developing depressive symptoms sometime in his/her life. (Sullivan, Neale & Kendler, 2000).
 - If one identical twin has manic-depression, the other twin has a 40-70% chance of developing the disorder (Craddock & Jones, 1999).
 3. Depression may be caused by an imbalance in the level of chemicals in the brain. Many antidepressants work by regulating the levels of these chemicals (neurotransmitters).
 4. Medical illness may contribute to the emergence of depression.
 5. Use of certain medications may cause depressive symptoms (e.g., some anticonvulsants or thyroid hormones).
 6. Excessive use of alcohol and other drugs may contribute to depression, as alcohol acts as a depressant on the central nervous system. Further, substance abuse complicates the diagnosis and treatment of the underlying psychiatric disorder(s).

IV. The impact of depression on relationships

?

Discussion Questions:

- How does your loved one's depression affect your relationship?
 - Your family life?
 - Your view of yourself?
- A. Depression affects a person's behavior and style of communication (less eye contact, slower and softer speech, negative thinking, reduced problem-solving abilities).
- B. Depression is often accompanied by an increase in marital tension and arguments.
- C. Depressed people have greater difficulty interacting with others. Therefore, the social life of the couple/family may be altered.
- D. Some depressed people are unable to work. Therefore, other family members may have to get a job for the first time or work two jobs to compensate for the reduced income.
- E. Family members often become frustrated with the depressed person's behavior, thinking the consumer should just "get over it" or "cheer up."
- F. Depressed people often have decreased interest in physical intimacy and sexual activity. Partners often worry that the consumer is no longer physically attracted to them, which can increase the tension in the relationship.

V. Important issues surrounding suicide (parts adapted from Woolis, 1992)

FACILITATOR NOTE: As these issues may be difficult to discuss, you may wish to normalize any anxiety when talking about these issues. Also, you may choose to include your facility's suicide prevention coordinator in this session, as he/she likely has considerable expertise in dealing with issues of suicidality.

- A. Many family members worry a great deal that their loved ones may try to kill themselves.
1. Individuals with mental illness commit suicide at a rate that is considerably higher than that of the general population.
 2. Over 90% of suicides are associated with a mental disorder or substance-abuse problem (often in combination) (Moscicki, 2001).
 - a. More specifically, one third of all clinically depressed people attempt suicide (www.psychiatry.medscape.com/reuters/prof/2000/05/05.15).
 - b. According to the National Strategy for Suicide Prevention, about 6-15% of people diagnosed with schizophrenia end their lives via suicide. (www.mentalhealth.samhsa.gov).
 3. Men are four to five times more likely to complete suicide than women. Women are three times more likely to attempt (but not complete) suicide than men (Moscicki, 1995).
- B. People consider and attempt suicide for many reasons, including the following:
1. Some make a decision to end their lives – they are very unhappy with their lives and feel hopeless that the situation will improve.
 2. Some engage in reckless behavior because they don't think they will die (e.g., jump off a tall building believing they are super-human). Their judgment is impaired, and they may not understand the consequences of their behavior.
 3. Some hear voices telling them to harm themselves.
 4. Some do not know how to ask for help directly but kill themselves unintentionally (e.g., take too much pain medicine; cut wrists, etc.)
- C. “Red flags” that warrant further exploration include the following:
1. Changes in the level of depression (more depressed or happier than usual), especially if he/she
 - a. Has a specific plan for how to kill him/herself
 - b. Has access to lethal means (such as weapons, pills, etc.)
 - c. Feels worthless
 - d. Talks about having done an unforgivable behavior
 - e. Feels hopeless about the future
 - f. Hears voices saying to harm him/herself

- g. Begins to get his/her affairs in order (e.g., writes a will, gives things away, systematically contacts old friends or relatives)
 - h. Has experienced a recent significant loss (or perceived loss)
 - i. Lives with chronic medical illness and/or chronic pain
2. Has previously attempted suicide or has a history of being impulsive
 3. Talks about killing him/herself (e.g., “Everyone would be better off without me”)
 4. Makes suicidal gestures (takes too many pills, cuts wrists, etc.)
 5. Talks about being indestructible or having supernatural powers during a manic or delusional state
 6. Increases use of alcohol or other drugs. These substances may increase the level of depression AND may lower inhibitions, both of which are dangerous with suicidal people.

D. What to do if your family member is suicidal

?

Discussion Questions:

- What have you found to be helpful for yourself and for your loved one when he/she shares thoughts of suicide?
 - How do you feel in these situations?
1. Talk about it. Asking about suicide will not put ideas in the person’s head and will not make the situation worse. Your family member may even feel relieved to be able to talk about it.

Discussing suicidal ideation can be very important, as 50-70% of people who complete suicide communicate their intent in advance, usually to a family member (Adamec, 1996).
 2. Offer emotional support by:
 - a. Listening in a nonjudgmental, compassionate manner
 - b. Empathizing with the person’s feelings (e.g., “It must be awful to feel that way”)
 - c. Reminding the person of recent accomplishments
 - d. Normalizing depression and thoughts of suicide
 - e. Expressing your concern, care, and willingness to help
 3. Ask if he/she has a plan about how to kill him/herself. If your family member describes a specific plan, then:
 - a. Seek professional help immediately

- b. Try to get him/her to promise that he/she will not act on these plans without first talking to you, a hotline, or a mental health professional
 - c. Put away any objects that your family member may use to harm him/herself (guns, knives, pills, razors, etc.)
4. If the person is delusional (expressing false beliefs), seek professional help.
 5. If you don't know what to do, call a professional (e.g., suicide hotline, mental health professional, police)
 - **National SUICIDE Hotline:** 1-800-SUICIDE
 - **Veterans Affairs Suicide Hotline:** 1-800-273-TALK (8255)
Suicide hotline in Oklahoma City: (405) 848-CARE
 6. Sometimes suicide happens without warning, and nothing can prevent it from occurring.
 7. Even with warning signs, there still may be nothing you can do.
 8. Family members can benefit from discussing this issue with their loved ones when they are not actively suicidal. Together, the family and consumer can create a plan for coping with this inherently stressful situation if it arises again in the future.
 9. Consider seeking professional help for yourself. Families often experience intense anxiety, worry and feelings of powerlessness when loved ones make suicidal threats.

VI. Local treatment options for individuals living with depression and bipolar disorder

Example: Oklahoma City VA Medical Center

A. Depression Management Class

- This eight-session class consists of three modules, and helps veterans to increase their pleasant activities, modify dysfunctional thought patterns, and improve their interpersonal skills.

B. Medications

- Primary care providers can prescribe many medications for depression and bipolar disorder. In addition, psychiatrists in the mental health units have special training in prescribing and monitoring psychiatric medications.

Support And Family Education:
Mental Health Facts for Families
Michelle D. Sherman, Ph.D.

- Medications for depression and bipolar disorder are not habit forming, so consumers do not have to worry about becoming addicted to the drug.
 - For major depression, antidepressants are quite effective. Most studies demonstrate at least a 50% decrease in symptoms for approximately 70% of people (Tamminga et al., 2002). A class of medications known as selective serotonin reuptake inhibitors (SSRIs), including medications such as Prozac, Zoloft, and Paxil, often have few side-effects and are helpful to many people living with depression.
 - For bipolar disorder, many mood stabilizers are effective in helping consumers lead meaningful, productive lives and enjoy close relationships.
 - Lithium was the first medication introduced to treat bipolar disorder, and it is effective for many consumers.
 - Other medications (e.g., Depakote and Tegretol), which were originally created to prevent seizures, are also helpful in stabilizing moods.
 - Newer medications (e.g., anti-seizure medications like Neurontin and Topamax and anti-psychotic medications such as Clozaril, Zyprexa, Risperdal and Seroquel) are also being studied to assess their usefulness for people with bipolar disorder.
 - Sadly, medication compliance can be very challenging for these consumers because, although their moods may be less intense and cyclical, they miss the extreme enjoyable highs of mania. An excellent resource for consumers and families dealing with bipolar disorder (especially medication compliance) is *The Bipolar Workbook: Tools for Controlling Your Mood Swings* by Dr. Monica Ramirez Basco.
- C. The REACH Project (Reaching out to Educate and Assist Caring, Healthy Families) – This 9-month family psychoeducation program provided by the Family Mental Health Program supports veterans and their family members in dealing with depression and bipolar disorder. The program involves both single-family therapy and multi-family groups/psychoeducational classes. Sessions are held in the evenings to accommodate participants’ work schedules.
- D. Day Treatment Center – The Day Treatment Center provides a structured, intensive program for veterans experiencing chronic mental illness (including depression).
- E. Electroconvulsive Therapy (ECT)
- Electroconvulsive Therapy (ECT), also known as shock treatment, is a safe and painless (yet rather controversial) treatment option for consumers with severe depression who do not improve with medications. The success rate of

ECT (80-90%) is higher than that with antidepressants (approximately 70%). ECT is administered by deliberately inducing a seizure, and the potential adverse effects of this procedure (e.g., confusion and memory loss) must be considered (Datto, 2000; Fink, 2001; United Kingdom ECT Review group, 2003).

- The consumer should discuss this option with his/her psychiatrist if interested in this treatment.

VII. Coping strategies for the family

A. Do's

1. Acknowledge that clinical depression and bipolar disorder are legitimate illnesses. Learn about depression and its impact on the family.



Good Books on Depression:

The Feeling Good Handbook. (1999). D. Burns. New York: Viking Penguin.

What To Do When Someone You Love Is Depressed: A Practical, Compassionate, and Helpful Guide for Caregivers. (1998). S. & M. Golant. New York: Henry Holt & Co.

When Someone You Love Is Depressed. (1996). L. Rosen & X. Amador. New York: Free Press.

Good Books on Bipolar Disorder:

The Bipolar Disorder Survival Guide: What You and Your Family Need To Know. (2002). D. J. Miklowitz. New York: Guilford.

Bipolar Disorder: A Guide for Patients and Families. 2nd ed. (2006). F.M. Mondimore. Baltimore: Johns Hopkins University Press.

Surviving Manic Depression: A Manual on Bipolar Disorder for Patients, Families, and Providers. (2005). E.F. Torrey & M.B. Knable. New York: Basic Books.

For Youth:

I'm Not Alone: A Teen's Guide to Living with a Parent Who Has a Mental Illness. (2006). M. D. Sherman & D.M. Sherman. Edina, MN: Beaver's Pond Press.
Available at www.seedsofhopebooks.com

Wishing Wellness: A Workbook for Children of Parents with Mental Illness. (2006). L.A. Clarke. New York: Magination Press.

Relevant Web Sites:

www.depression.org – comprehensive resources about depression

www.dbsalliance.org – Depression and Bipolar Disorder Alliance

www.depressionfallout.com – help for those dealing with a depressed loved one

www.familyaware.org – Families for Depression Awareness

2. Have realistic expectations (e.g., depression cannot go away overnight)...but also maintain hope.
 - a. New antidepressants and treatment strategies are being studied and becoming available. Many people with depression are able to lead constructive lives.
 - b. For example, the movie *Patch Adams*, starring Robin Williams, depicts a young man admitted to a psychiatric unit because of major depression and suicidal ideation, who later becomes a successful physician.
3. Be an active team member in the care of your loved one. Ask questions of doctors, nurses, psychologists, and other healthcare providers.
4. Offer emotional support, patience, and compassion. Encourage your loved one to exercise and do activities that he/she used to enjoy. Allow your loved ones to care for themselves as much as possible.
5. Stay in contact with your social support network.
6. Obtain professional help for yourself when needed.
7. Maintain good sleep habits, both for you and your loved one (e.g., go to bed and get up at the same time every day; reduce caffeine intake). Research has found that disrupted sleep patterns can trigger bouts of depression or mania (Frank et al., 2005), so regular sleep/wake times are very important.
8. Make healthy lifestyle choices (healthy diet; regular exercise; avoid use of alcohol).

B. Don'ts

1. Try not to take the depression personally – it's not your fault! You cannot cure depression with love any more than you can cure cancer with love.
2. Don't exclude the depressed person from family discussions or decisions.
3. Don't try to do everything for the depressed person.
4. Don't criticize the person for his/her depressed behavior or expect him/her to be able to simply "snap out of it."
5. Don't feel that you need to apologize for your loved one.