Information for patients
and their relatives

Depression
Identify – Cure

Table of contents

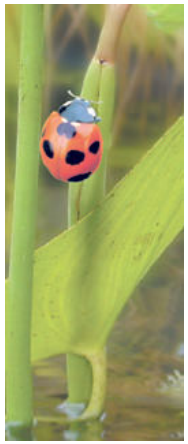
Synopsis for the hasty reader

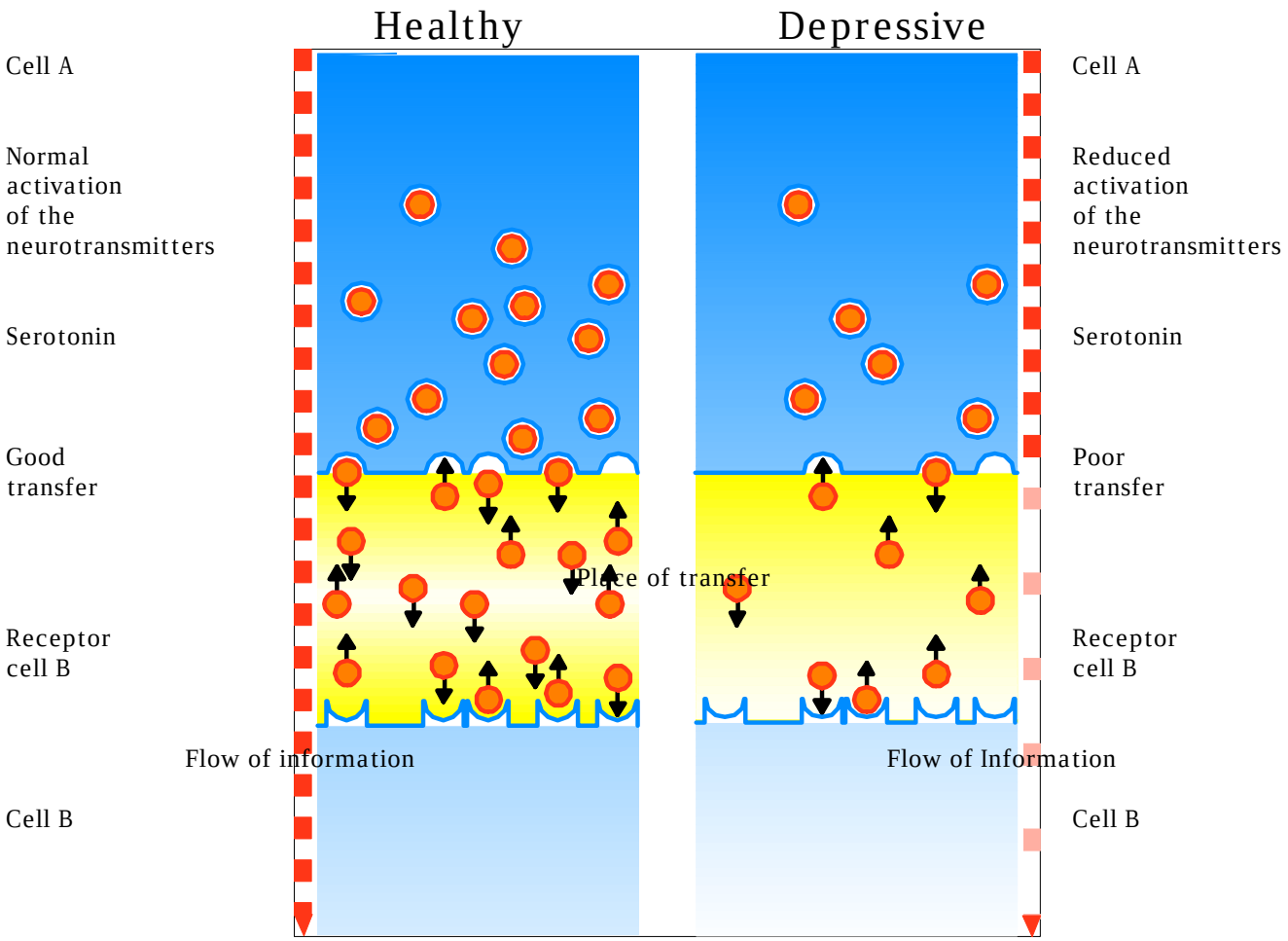
- Depression is an illness that should be regarded seriously; symptoms include moodiness, anxiety, uneasiness, mental distress, and insomnia. It is characterised by a metabolic disorder in the brain.
- Mourning or a sorrowful mood after a deeply felt loss is not depression.
- Depressive persons cannot be happy and can only with great difficulty make even simple decisions.
- Depression is often accompanied by persistent physical afflictions.
- Depression can often be recognised by means of pointed questions.
- Groundless feelings of guilt are essentially a sign of depression.
- In many instances, more often in the case of men, manifestations of depression can be quite different. Instead of being sad and withdrawn, they respond with aggressiveness, annoyance, and/or by an increased consumption of alcohol. They participate excessively in sport, depending on the circumstances, and feel stressed and burnt out.
- Like all seriously ill persons depressive people require understanding and support from their environment.
- Depression can be cured. Treatment includes mood- brightening medicines – antidepressants – and various forms of conversational therapy.
- Antidepressants do not have an immediate effect. They usually require at least several days or weeks before an improvement is noticed.

Lundbeck (Schweiz) AG
Dokument letztmals geprüft: 14.03.2006
Version 1.0

What happens in the brain when one is depressive ?

- Antidepressants treat the symptoms of depression and should thus be taken as long as the affliction lasts.
- Recurring bouts of depression are amenable to preventive treatment.
- Depression often results in suicide. This danger can be recognised in time and suicide-prone persons should be treated medically as soon as possible.
- People who are predisposed to suicide can consult a general practitioner or a medical specialist; in addition they may turn to a crisis centre, psychosocial services or pastoral care by telephone.





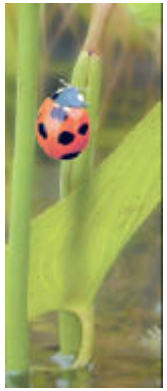
(Simplified representation)

What is depression ?

Depression is an affliction comprising moodiness accompanied by anxiety, restlessness, mental disruption and insomnia. Thought processes are retarded and usually involve only one topic, namely how bad things are, how hopeless current prospects are, and how dreary the future seems to be.

Many patients have feelings of guilt and sinfulness that could lead to serious delusions. It is known as pensive compulsion, since the same negative thoughts are continually and inevitably contemplated. On the one hand insomnia manifests itself in difficulties with falling asleep, with frequent interruptions, and on the other hand by waking early.

Consequently sleeping is experienced as insufficient and superficial and in the morning one feels unrefreshed. Mornings often are the worst time for depressive patients, since they then feel very bad. Their condition can improve in the afternoon until it is relatively bearable towards evening. This abysmal misery in the morning is called the morning low.



When is it not depression ?

Not every sad mood is a state of depression. Depression is distinguished from sadness by noting that a depressed person is unable to be pleased about anything; also he/she can only with great difficulty make decisions. Often they cannot make any decisions at all and do not, in the morning, know whether they should get up or stay in bed.

The difference between sadness/mourning and depression can be noted at a funeral when relatively few attendants are really grief-stricken. Close relatives of the deceased may nearly collapse at the graveside, but when the life of the deceased is discussed an hour later during a meal, some anecdote may raise a smile or even outright laughter among the relatives.

For a seriously depressed person even a smile would be impossible. They are unable to experience pleasure or joy. Depressive persons are often unable to make decisions; in contrast, mourners can, after a short time, make amazingly quick and clear decisions. A mourner can be distracted, but a seriously depressive person not at all.

Depression and physical complaints

Depression is often accompanied by stubbornly persistent physical complaints. Such symptoms include headaches, neck- and lower back pains, pains in arms, legs, and chest, a feeling of constricted breathing (this is often experienced as a heavy stone lying on the breast), vague heart pains, indigestion (either in the form of diarrhea or constipation), upset stomach, gripes, and convulsive abdominal pains.

Such physical afflictions may be so much in the foreground that the real underlying mental cause can often not be diagnosed at all. Both the patients and their relatives very frequently think that it is a case of physical affliction. Medical examinations then usually cannot identify any physical causes for the illness. Only a discussion of the patient's frame of mind can bring clarity. Such cases are known as disguised or masked depression, because the depression is hidden behind the physical symptoms like behind a mask.

This situation is often made more difficult when the patients are convinced that they are physically ill, while the thought of being mentally afflicted would be regarded as a weakness or a disgrace. When they are told that their illness is mental and not physical, they may respond indignantly and insultingly, and reproachfully accuse you of regarding the patient as hypochondriac or hysterical, which is actually not the case.

How do we recognise depression ?

The following questions should be considered for finding the correct lead:

- Is it still possible to be glad?
- Is it as easy as before to make decisions?
- Did the patient's mood deteriorate before the physical afflictions became evident, or was it the other way round: did the moodiness follow after the afflictions?
- Is anxiety present?
- Are there sleep disturbances like not falling asleep, sleep interruptions, or waking early?
- Is the person's state of health in the morning worse than in the evening?
- Do depression, suicide or alcoholism occur among family members or relatives?
- Have similar conditions occurred previously, or were there depressive moods at times, or periods of exceptional activity leading to a feeling of happiness?

Feelings of guilt – sign of depression

A great source of difficulties for depressive patients is that they think they have at some stage been personally stricken by a unique misfortune and that nobody else has such feelings of guilt or thoughts of suicide. It is thus very important that these people should be told that they really are ill and that their misery is not the result of having become guilty at some stage; but that feelings of guilt are symptoms of this illness.

Depression – a common affliction

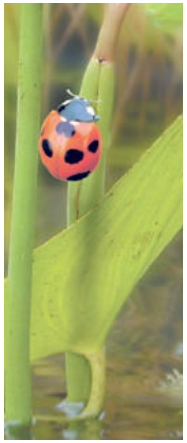
Depressive persons should be made aware that depression is one of the most common diseases. According to estimates of the World Health Organisation 3 % to 5 % of the world's population suffer from depression on any one day. This amounts to between 120 million and 200 million people per day.

The probability of being afflicted by depression during the course of one's life is estimated at 20 % to 30 %. This means that every third person probably suffers from acute depression at one time or another during his life. But nobody can avoid slight temporary depressive moods.

Depression - a mortally dangerous illness

The tendency to take one's own life is a very dangerous problem in cases of depression. This tendency arises from the feeling of seeing no other way, of absolute pessimism and of hopelessness. Depression is regarded as one of the most common causes of suicidal acts, whether actual or attempted.

It is therefore important to know the magnitude of the risk in every case of depression. This can best be estimated by asking the patients directly about the intensity and frequency of their thoughts of suicide. It has long been thought that one should not discuss suicide with depressive persons since it might give them ideas. This is basically erroneous because every depressive patient does consider the possibility, and it is a relief when it can be discussed openly.



When is suicide a real danger ?

Further indications for estimating the danger are obtained when the patients are asked whether they think generally about the possibility of suicide, or whether they have definite ideas about how to do it. The more definite these ideas, the greater the risk. The risk is even greater when the persons involved have already made preparations, for example by obtaining prescriptions for soporifics from different doctors, or acquiring a firearm or a suitable rope. Professor Erwin Ringel has described three important signs that specially indicate a suicidal tendency:

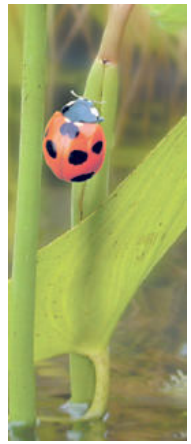
1. Constriction
The patients feel that they are in a constricted situation from which there is practically no escape. Their thoughts continually revolve around these problems and they also experience social strictures in which they are increasingly isolated and lonely.

2. Reversal of aggression
This means that people suffering aggression and who for various reasons are unable to make work of it or discuss it, subsequently direct the inhibited aggression against themselves.

3. Fantasising about death
Suicide-prone people usually think about the various possibilities of taking their own life, or they imagine how their relatives would mourn their demise. They can also picture their own funeral. In the case of such death fantasies it is important to ask whether these fantasies are evoked at will, or whether they enforce themselves involuntarily. The more these ideas surface involuntarily, the greater is the risk.

Prompt help in times of crisis

Suicidal thoughts and intentions are very common; it is thus impossible to treat all patients in hospitals. But it is extremely important that medical treatment should be immediately available, since not only can the depressive mood be treated, but also the suicidal thoughts and intentions. It is thus very important to induce depressive patients to consult a doctor or at least call a pastoral telephone service anonymously, a crisis centre or a psychosocial service. Such institutions are becoming increasingly numerous nowadays. Telephone numbers may be obtained from doctors or in the local telephone directory.



How to live with depressive patients

1. Depressive patients are ill. They are neither lazy, nor hysterical nor hypochondriacs.

2. Depression is an illness that can be treated and cured; it is therefore important that depressive patients receive medical treatment as soon as possible.

3. Since depressive patients find it extremely difficult to make decisions, they should not be forced to make any decisions during their illness. They would regret it after the depression has subsided.

4. There is no point in sending depressive patients to a health or a convalescent resort, especially not people in an acute depression, since they would become even more lonely and have enough time to brood over their apparent misfortune. Suicidal tendencies would then be aggravated. This does not hold for patients who have overcome the illness (see Par. 8).

5. Depressive patients cannot be voluntary, and it is thus meaningless to appeal to their will. Such an appeal may even cause deterioration of their condition, since the patients then realise that they do not want to want; this causes further acute misery. It also does not make sense to ask such people to pull themselves together or to participate in certain activities. This is only experienced as agony.

6. It is important for patients that their relatives support them in the regular taking of medicine and eventually to oversee this discreetly. It could be fatal to dissuade the patient from taking the medicine. In this regard it is important to note that antidepressants are not habit-forming.

7. The real risk involved in suicidal tendencies should be discussed openly with depressive patients for the purpose of visualising the risk. One should remember that acute cases of patients having suicidal tendencies would try to disguise or hide their intentions because of the fear of being prevented to carry out their plans. Acutely suicide-prone patients should therefore be treated in a hospital.

It is important to accept the depressive patients' portrayal of their condition. If one would try to convince them that their condition is better than what they feel, you only lose their trust. Depression is a serious illness and one is justified to refer them to a health resort or a convalescent home for recuperation, but only after their condition has improved. As emphasised above, this should never happen during a time of depression, only afterwards.

Treatment of depression

Since the discovery of mood-brightening medicines, the so-called antidepressants, all kinds of depression can also be treated by means of medicines. This is one of the quickest-working and most intensive treatments.

Antidepressants have different effects on different people. If you think that the prescribed remedy does not have the desired effect after a few weeks, or has (very) unpleasant side effects, do not hesitate to discuss it with the doctor. Based on your feedback he can then select a more suitable course of treatment.

In addition to medicinal treatment, different forms of conversational therapy may also be of significant value.

Preventive treatment of depression

In the case of periodically recurring depression or even manic-depressive manifestations, one single treatment would be insufficient. Then a prophylaxis comprising a series of preventive measures can be undertaken. Lithium compounds are the first choice. For certain types of depressive afflictions, namely periodically recurring depression, antidepressants can also be used preventively.

Duration of treatment – Duration of illness

Antidepressants do not have an immediate effect. In most cases several days or even a few weeks may be required.

Depression can last for weeks or months. It may thus be necessary to take the medicine regularly over an extended period. Your doctor will discuss the anticipated duration of the treatment and also, if necessary, the prevention of relapses.