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Original Article

Mood disorders, symptoms and treatment in the family's perspective

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Objective: to understand the perception of family members of patients diagnosed with a mood disorder concerning the disease, its symptoms and treatment. Method: qualitative case study with relatives of patients diagnosed with mood disorders undergoing treatment in a psychiatric hospital. Data were collected by semi-structured interviews and analyzed by content analysis. Results: misinformation and stigma permeate this panorama, weakening relationships and impairing family support and treatment, which involved medication, psychotherapy and electroconvulsive therapy. Conclusion: mood disorders, given their complexity and prevalence, must be understood by society, families and professionals. The family is affected by mental suffering and needs to be the focus of care.

Descriptors: Mood Disorders; Family; Psychiatry; Social Stigma.

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Transtornos do humor, sintomas e tratamento na perspectiva dos familiares

Objetivo: compreender a percepção de familiares de pacientes com diagnóstico de transtorno de humor em relação à doença, sintomas e tratamento. Método: estudo de caso qualitativo realizado com familiares de pacientes com diagnóstico de transtorno de humor em tratamento em hospital psiquiátrico. A coleta de dados ocorreu por meio de entrevistas semiestruturadas e os dados foram submetidos à análise de conteúdo. Resultados: a desinformação e o estigma permeiam esse panorama, fragilizando relações, prejudicando o suporte familiar e o tratamento, que envolveu medicamentos, psicoterapia e eletroconvulsoterapia. Conclusão: os transtornos do humor, dadas sua complexidade e prevalência, necessitam ser compreendidos pela sociedade, família e profissionais. A família é afetada pelo sofrimento mental e necessita ser foco do cuidado.

Descritores: Transtornos do Humor; Família; Psiquiatria; Estigma Social.

Trastornos del humor, síntomas y tratamiento en la perspectiva de los familiares

Objetivo: comprender la percepción de familiares de pacientes con diagnóstico de trastorno de humor en relación a la enfermedad, síntomas y tratamiento. Método: estudio de caso cualitativo realizado con familiares de pacientes con diagnóstico de trastorno de humor en tratamiento en hospital psiquiátrico. La recolección de datos ocurrió por medio de entrevistas semiestructuradas y los datos fueron sometidos a análisis de contenido. Resultados: la desinformación y el estigma permean ese panorama, debilitando las relaciones, perjudicando el soporte familiar y el tratamiento. Conclusion: los trastornos del humor, dada su complejidad, necesitan ser comprendidos por la sociedad, la familia y los profesionales. La familia es afectada por el sufrimiento mental y necesita ser foco del cuidado.

Descriptores: Trastornos del Humor; Familia; Psiquiatría; Estigma Social.

Introduction

Mental disorders are multi-causal, and they and are associated with increased use of psychoactive substances, different ways of life and their implications for modern life[1].

Mental suffering damages people's relationships and their entire social and support networks. Their families, in particular, undergo a number of changes in their structure and functioning due to the diagnosis, treatment and its side effects as well as to changes in the behavior and abilities of individuals with mental disorders[1].

With regard to mood disorders, these are divided into unipolar depression and bipolar disorder. The bipolar mood disorder is characterized by manic episodes showing abnormal, elevated, expansive or irritable mood and increased activity and energy, as well as hypomania episodes, which are less severe than manic events[2].

Unipolar mood disorder, or depression, however, is a persistent mood disorder, characterized by depressed mood and decreased interest in almost all activities that an individual performs[2-3].

The treatment is similar for both, namely, pharmacological treatment, psychotherapy and electroconvulsive therapy[3]. However, the response to therapeutic strategies varies from individual to individual, as well as the adverse effects faced and the reflection of such effects on family members and social relationships.

Thus, the objective is to understand the perception of family members of patients diagnosed with mood disorders concerning the disease, its symptoms and treatment.

Method

This is a qualitative case study conducted in a philanthropic psychiatric hospital located in the city of Belo Horizonte, Minas Gerais.

The study subjects were 20 relatives of outpatients with mood disorders undergoing treatment at the hospital. The inclusion criteria in the study were: being over 18 years old and being a family member of a patient diagnosed with severe depression, refractory to biological treatment, or diagnosed with bipolar disorder.

Data were collected from December 2016 to February 2017. To that end, a semi-structured interview with questions regarding the therapeutic proposals offered, the implications of treatment and family members' perceptions of the patient's clinical condition was used along with diary on which notes concerning the researcher's impressions were taken. The interviews were audio recorded and fully transcribed, with excerpts from family members' statements being identified as F1, F2 ... F20.

Analysis was performed using the content analysis method proposed by Bardin. Content analysis is a set of methodological instruments in constant improvement that are applied to a variety of discourses[4].

The steps of content analysis are: 1) pre-analysis, an organization phase whose objective is to systematize the initial ideas; 2) exploration of the material, which consists of coding and enumeration operations, according to formulated rules; and 3) treatment of results, which are submitted to statistical and validation tests. These results can, then, propose inferences and interpret the proposed objectives.

From the content analysis, three thematic categories emerged, which will be discussed in the results of this article: 1) Predisposing factors to the development of mood disorders; 2) Symptoms of depression from the perspective of family members; 3) Family members' perception of mood disorders and therapeutic strategies.

The project was approved by the Research Ethics Committee of the Federal University of Minas Gerais (COEP 35574914.3.0000.5149), and all participants signed an Informed Consent Form. There was also prior consent from the participating institution to conduct the study.

Results and Discussion

Depression consists of a persistent mood disorder, characterized by depressed mood that presents itself as a functional disabling condition, in addition to compromising physical health and quality of life[2-3].

A feeling of sadness, anhedonia, excessive guilt, worthlessness, psychomotor delay or agitation, difficulty concentrating, insomnia, appetite and weight changes and decreased libido are identified as common symptoms in depression, depending on its severity[2,5]. The intensity of signs and symptoms differs for each individual, as shown in excerpt F3, where it is described as "a feeling of sadness", and in excerpt F2 as "thoughts about death".

In 2015, she had a crisis with hallucinations, agitation, insomnia; she really freaked out, and then, in 2016, she started a series of hospitalizations. (F1) *In 2004, the symptoms of depression began. He worked and had a life perspective and, from then, he didn't feel like doing anything; he was very discouraged, had insomnia and didn't feel like working; he attempted suicide for the first time.* (F2)

Suicidal behavior or ideation is common in individuals with major depressive disorder, which contributes significantly to early death. A study reports that 90% of suicides had some type of mental disorder involved and, of these, 40% of the individuals were

diagnosed with depression[6]. Therefore, there is a need to identify depression symptoms, as mentioned by F3, and to start treatment early.

She was discouraged and felt like doing nothing; she just wanted to lie down, was anguished, shaky, confused; she just talked about negative things. (F3)

In excerpts F2 and F3, the difficulty of patients affected by depression in carrying out daily activities, such as staying active and working, is perceived. A study points out that, in the United Kingdom, 35% of reports of illnesses linked to work are related to mild or moderate depression and that, according to the World Health Organization estimates, depression is the main cause of long-term sick leaves in Europe[7].

It is noteworthy that, according to the current mode of social organization, work consists in one of the main social contractual elements, that is, working and having a work income gives the individual social status and, therefore, social value[8-9]. From this social conception of work and the consequences of depression, an individual who does not produce economically, even if due to illness, loses the power of social contract, becoming incapable. Thus, such "lesser value" and social isolation aggravate the disease and interfere with treatment.

Due to these factors, it is extremely important to address the impact of depression on work during the individual's treatment and to include the family in pursuing the understanding of such process.

The occurrence of mood disorders is significantly associated with genetic inheritance, the use of psychoactive substances and environmental stressors, such as traumatic events[2,10]. Thus, the importance of family members' and the patient's understanding the external factor that led the latter to develop a mood disorder is acknowledged:

My mother started showing depression when we lost a very close nephew. That nephew was with my brother; they had an accident and my nephew died. She started showing the symptoms of depression about 20 years ago. Two, three years later, my brother passed away, so she got worse. (F6) *In September 2007, there was a robbery at the post office in Maranhão and, at the moment, the manager and he were there. During that robbery, a customer died next to him, and he had to pretend to be dead so he wouldn't die too. He coped with it for 15 days, as there was nobody to decide about the customer's funeral the post office credited some money to his account so he could solve the issue; from that day on, he froze, it seemed like he was in shock.*(F14)

In addition to traumatic events, studies report the importance of a father figure in the development of an individual's personality and in his/her ability to cope with adverse situations. Thus, not only does the father's emotional and/or physical absence impact a child's development, but it also leaves traces of insecurity, feelings of abandonment and loneliness and relational difficulty that extend to adulthood, which can trigger mood changes[11-12].

The family relationship is complicated; his mother was 18 years old when he was born, so he was raised by his great aunt; his father never took responsibility; he did not have a father figure. When he came to Belo Horizonte, he shared a house, but he had a crisis and, then, he moved back in with his great aunt. (F12)

In the context of mental disorders, it is common for individuals and their families to find difficulty in understanding what the disease is about, as well as the importance of adequate therapeutic monitoring in order to reduce recurrences.

Misinformation and stigma involve the panorama of mental suffering, such as depression and bipolar disorder, thus affecting the patient, the family, the treatment and access to social facilities[13].

Only 42% of family members are informed about depression, and this is in agreement with the reports in this study, in which misinformation about mental disorders can be observed[13].

I had no idea what it was; I heard about it and thought it was silliness. You only see it after you go through it. Today I know how difficult it is for a depressed person to get out of depression. (F2) *Look, the family is not educated; so, they did not know much about the disease; they thought that he was just slacking off, that prayers would solve everything; it's been complicated up to this day.* (F8)

Behavioral disorder carries with it a social stigma, and the act of revealing its existence, whether in oneself or in a family member, causes fear, which is why many people prefer to hide or deny the disease, as shown by F14.

It seems that she (the mother) is ashamed of what he has. When we lived close to her and I gave him his medicines, she would tell him not to take them because they were for crazy people. He even stopped taking some medications because of that. (F14)

When compared to other mental disorders, such as schizophrenia, there are beliefs that depression involves more social factors and fewer chemical factors. Thus, improvement would be related to willpower, which results in less demand for professionals and treatment. Misinformation favors the emergence of negative feelings, generating prejudice, discrimination and rejection by the social circle, thus contributing to underdiagnosing and non-adherence of patients to pharmacological treatment[14].

With the removal of friendship bonds, the family becomes the main or the only cycle of interaction for the patient. However, such bond may be weakened, since, in

this study, family members reported challenging, stressful and tiring coexistence with people with mental suffering.

He complained a lot about his friends because they left. (F2) *The relationship between a mother and a child is very different; there is little communication as far as I can notice, even as a result of depression.* (F12)

On the other hand, as reported by F4, illness becomes a factor of family cohesion, enabling greater interaction among individuals.

We became very close after he fell ill. He was not very close before because he was very active; he worked a lot. (F4)

Depressive symptoms trigger feelings of vulnerability, making individuals even more in need of social and family support, enhancing adherence to pharmacological treatment and encouraging improvement, thus achieving therapeutic success[15].

In addition, there is the so-called courtesy stigma, which reflects the stigmatizing condition of depressed individuals' family members, which can impair family support, self-acceptance and adherence to treatment[13].

Thus, escape and avoidance are strategies commonly used by family members of people with mental suffering, which favors the maintenance of fear, stigma and psychological problems[1].

Studies show that the greater the severity of the case, the greater the stigma. Likewise, some factors are related to lesser stigma, such as higher educational level, being a health professional and the presence of a traumatic event as a causal factor[14].

Depression tends not to be correctly diagnosed, and patients do not seek specialized care, which compromises therapeutic efficacy. There are three treatment modalities: pharmacological, psychotherapy and electroconvulsive therapy[3].

Chemically, depression is caused by an imbalance in the production and functioning of neurotransmitters, such as serotonin and endorphins, responsible for feelings of well-being, comfort and pleasure[5].

Thus, pharmacological treatment of mood disorders aims to eliminate symptoms and recover functional and social capacity as well as prevent disease recurrence[3,10]. From the reports, it is possible to perceive situations in which drug therapy has achieved the desired effects:

I think the medications were very effective for his depression because even though he was apathetic, he was calmer; I had a lot of tough times with him when the drugs were not working, he had crises, he was aggressive. (F14)

However, medications have a late onset of response and many have adverse effects, such as excessive sedation, postural hypotension (and consequently the risk for falls), urinary retention, in addition to possible cardiac interference, increased appetite and weight gain, which makes it difficult for patients to accept and adhere to treatment. Other factors lead to non-adherence, such as improvement in symptoms, beliefs and attitudes towards depression, stigma and disbelief in the effectiveness of treatment[16].

In addition, the history of treatment fallibility intensifies the stigma suffered by patients[13]. Several family members reported problems arising from medications, which led to the choice of alternatives such as therapeutic strategies:

The drugs cause constipation, very dry stool, a dry mouth. They sometimes make you dizzy. When they make you dizzy, the doctor has to reduce them because of age as there is risk for falling. (F3) *I think the medications were not good; she was very rigid, aggressive; she was strange; her hands were rigid.* (F10) *The previous treatment was medication and therapy. Nowadays, he continues with therapy. It had many side effects, such as sleep disruption, food; I didn't notice the expected effect, decreased libido. I didn't see the expected effect, and he was frustrated by it. It seems like it wasn't working.* (F12)

The significant adverse effects of medications and their influence on the daily lives of users are noticed as they make them frustrated, thus contributing to non-adherence to pharmacological treatment.

When these treatments are not effective, the side effects are exacerbated or, if the patient has suicidal ideas, the strategies used are dose increase, medication change, drug combination, psychotherapy and electroconvulsive therapy (ECT)[17].

What led to the start of ECT was the fact that the medications were not enough to bring a good result. (F4) *The medication did not have the desired effect, so she was hospitalized. Then, they decided to use ECT.* (F9)

Electroconvulsive therapy consists of applying electrical discharges to the individual's brain, the indications for which are non-response to drugs, serious or unavoidable side effects and worsening of clinical conditions[18].

Psychosocial interventions, such as psychotherapy, play an important role, and are very effective to treat mood disorders. This treatment, concomitant with pharmacological treatment, promotes symptom relief and greater adherence to pharmacological treatment, aids in psychic reorganization and provides patient support[10].

Since then it has been psychological counseling by a psychiatrist and a neurologist. (F14)

Thus, depression treatment involves, in addition to complex clinical criteria, strategies to reduce and fight stigma and prejudice through educational actions, means of communication and direct contact with people with mental suffering[13].

With regard to health care, it is observed that nurses, health-teams leaders, are not prepared to assist patients with mood disorders as they do not identify symptoms and provide incomplete care. Thus, comprehensive care is necessary, so that individuals have access to appropriate treatment and can participate as community members[5].

In addition, when observing the family's fragility, health professionals play a fundamental role in helping to cope with mental suffering, by bonding and recognizing the complexity of the multiple situations experienced in this context, from providing information to technical and psychological support[1].

Conclusion

Mood disorders have become Public Health issues since they are pathologies that negatively influence the individual's quality of life. As such, they must be understood by the population, family members and health professionals.

It is noted that, due to the complexity of understanding mood disorders, their symptoms and treatments, stigma and prejudice about this topic are created, which requires the development of educational actions to fight such scenario.

The family is a fundamental unit in patients' adherence to treatment and, at the same time, it is deeply affected by mental suffering; therefore, it also needs to be a focus of attention in the care provided.

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Authors' contributions

Research conception and design: Amanda Márcia dos Santos Reinaldo and Jéssica Maria Vieira Oliveira. Data collection: Jéssica Maria Vieira Oliveira. Data analysis and interpretation: Amanda Márcia dos Santos Reinaldo and Jéssica Maria Vieira Oliveira. Funding acquisition: no funding. Manuscript writing: Jéssica Maria Vieira Oliveira, Giulia Ribeiro Schettino Regne, Amanda Márcia dos Santos Reinaldo, Belisa Vieira da Silveira and Natália de Magalhães Ribeiro Gomes. Critical revision of the manuscript: Amanda Márcia dos Santos Reinaldo.

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