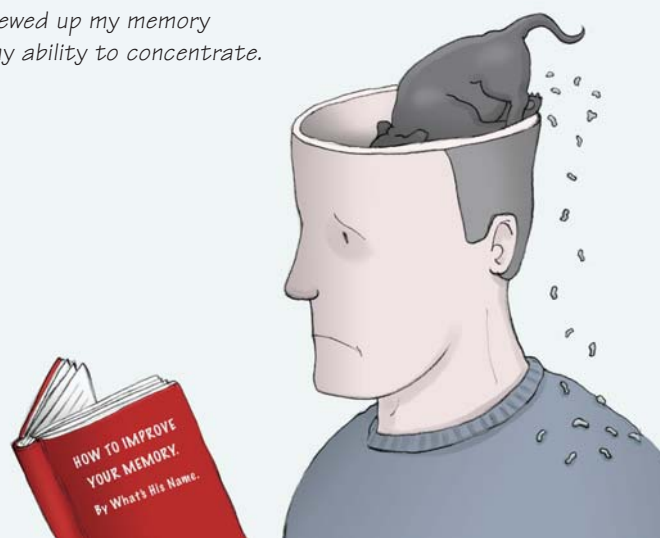




Activities that usually brought me pleasure suddenly ceased to.

He chewed up my memory and my ability to concentrate.



■ WORK/LIFE BALANCE

The seven Ds of

By GORDON PARKER

Lawyers are a group particularly at risk of suffering mood disorders, disabling conditions which are more common and less well diagnosed or treated than might be expected.

THIS ARTICLE HAS A '7 D' template. In essence, I argue that mood disorders are *distributed* widely, are *deadly* and *disabling*, lead to *discrimination*, are poorly *detected* and have been *dumbed down* via a *dimensional* model. Following that general overview, I'll go on to consider mood disorders in lawyers.

In terms of *distribution*, it is commonly accepted that about one in four women and one in six men will develop an episode of clinical depression over their lifetime. But 'clinical depression' is not a diagnosis – more a term capturing a level of depression beyond what might be termed 'normal depression'. In essence, the episode must be of some *severity* (as a consequence of multiple symptoms), be *persistent* – lasting at least two weeks, and result in significant *impaired functioning* or disability.

Turning to the bipolar disorders, these are conditions involving oscillating periods of 'highs' as well as depressive periods, with those having Bipolar I (previously called manic depressive psychosis) experiencing psychotic manic episodes. Those experiencing Bipolar II disorder have milder and non-psychotic 'highs' but equally impairing depressive episodes. Bipolar II disorder is probably 20 times more common than Bipolar I, appears to be increasing in younger age groups and the lifetime general population risk is now judged at about five per cent.

Depression is *deadly* – a staggering 80 per cent of people who kill themselves do so during a clinical depressive episode. The highest suicide rates occur in those with bipolar disorders (with quite comparable rates for both Bipolar I and II disorders), followed by those with the more biological melancholic disorders and then followed by those whose depressive con-



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"I Had a Black Dog" are featured here. This paper was presented at a forum, "Surviving and thriving in the profession", held in November as part of the 2007 annual assembly of NSW Young Lawyers.

ditions have psychosocial causes.

The mood disorders are *disabling*. A study undertaken by WHO, Harvard University and the World Bank, established that depression was the most disabling condition of all medical and psychiatric conditions, while bipolar disorder ranked sixth in the disability table. The reason is that these mood disorders come on at a young age, are recurrent, and episodes are often lengthy. Impairment doesn't just mean an inability to get to work – in fact, the greater level of impairment comes from depressed people who get to work but are unable to 'fire up' and therefore they function inefficiently as a consequence of the depressed mood and their impaired concentration.

Those with mood disorders still

Because of the shame and stigma associated with Black Dog, I became a champion at fooling everyone, both at home and at work.



Keeping up an emotional lie takes an incredible amount of energy. It's like trying to cover up epilepsy, a heart attack, or diabetes.



He liked to wake me up with very repetitive, negative thinking.

MOOD DISORDERS

Illustrations by MATTHEW JOHNSTONE

experience *discrimination*. One essayist in our 2006 writing competition stated, "I think that it would be easier to come to terms with losing your husband to another woman than to a black dog". Just as some women believe that no man could ever understand the pain of childbirth, an individual who has never experienced depression (even significant depression in response to a crisis) could not begin to understand the psychological pain of melancholic depression (which I will define shortly). While admitting to suffering from depression once commonly led to a 'pull up your socks' response by many family members and colleagues, such insensitive, inappropriate and unhelpful suggestions are less common as destigmatisation has occurred rapidly in this country.

However, while people with clinical depression are more inclined to talk about it openly, few with bipolar disorder are as comfortable, judging a greater risk to their career as a consequence of the mood swings and the negative connotations tied to the old term 'manic depressive psychosis'. The British comedian Stephen Fry (whose BBC documentary describes his mood swings from adolescence but who did not receive the correct diagnosis until he was in his late thirties) has defused some of the ad hominem overlay by stat-

ing that he suffers from "bipolar lite" (Bipolar II). This descriptor, however, can inflame others who recognise that bipolar disorder is – for most sufferers and their carers – a severe condition.

Discrimination extends to obtaining insurance – either general health insurance or travel insurance and even income protection. Any individual who admits to having a depressive or bipolar condition, will either not be able to get insurance or have to pay a significant premium.

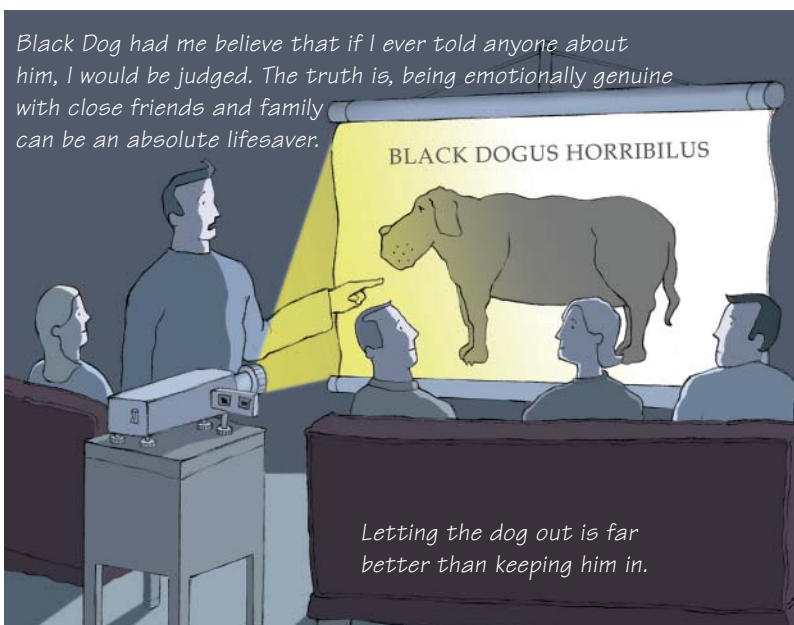
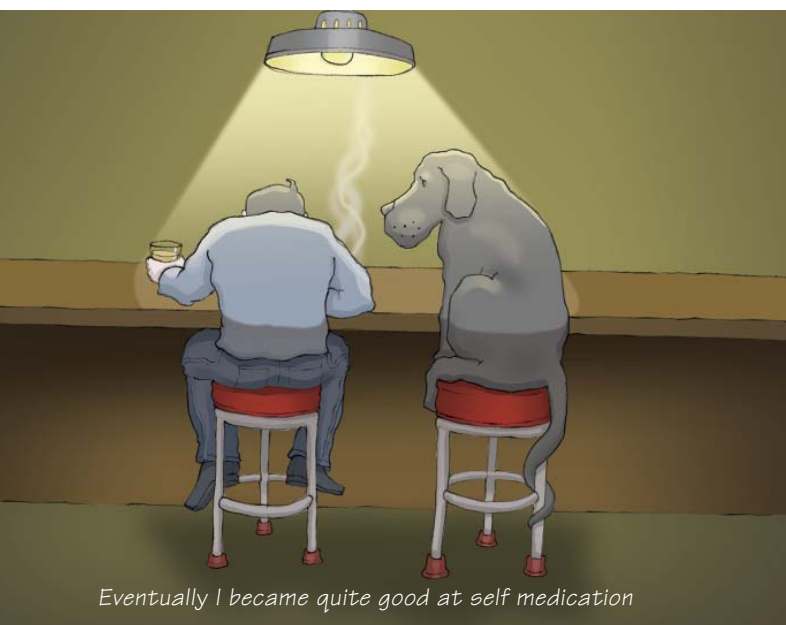
While the *detection* of mood disorders has improved in regards to determining whether somebody is clinically depressed (due to the training of health practitioners and the use of simple screening measures), there is still a major problem in the correct detection and diagnosis of bipolar disorder. Our studies suggest that of those who develop the condition (most usually in late adolescence) – and who subsequently receive a correct diagnosis (possibly the minority) – the average interval is 10 to 20 years. During that time, sufferers can effectively lose years of their life, while there can be considerable collateral damage in terms of work, personal relationships and problems with drugs and alcohol. Why? Firstly, individuals rarely present during a high and rarely complain about them (often they are pleasurable creative periods and a relief from depres-

sion), while many practitioners fail to ask the appropriate screening questions for bipolar disorder. These questions should be asked of all patients who present with clinical depression.

In comparison to most other areas of medicine, the diagnosis and management of mood disorders has been *dumbed down*. While we at the Black Dog Institute would argue that there are multiple meaningful differing types of depression, most classificatory systems view depression as a single entity, merely varying by severity. Just as observers can look at various parts of an elephant and provide quite different descriptions, varying professionals view depression as an 'it', and then manage the condition first on the basis of their own professional training and background, and then according to a 'universal' model (that is, assuming that their preferred treatment approach can be applied across all expressions of depression).

In essence, medical practitioners tend to view it as reflecting a chemical imbalance and therefore they tend to prescribe antidepressants. Psychologists view it as reflecting dysfunctional thinking patterns

Illustrations selected from "I Had a Black Dog" written and illustrated by Matthew Johnstone, Pan Macmillan rrp \$16.95. ISBN 0330421832.



in those who develop depression and therefore they recommend cognitive behaviour therapy or CBT. Counsellors tend to view it as a consequence of stressful life events and they recommend counselling and problem-solving strategies.

Thus, irrespective of the characteristics of the particular depressive sub-type, an individual is likely to get treatment dictated more by the characteristics of his or her practitioner than by the characteristics of the actual condition. This is a Procrustean model and is at variance with

sion. What does this feel like? In essence, this is a state where the individual feels that they are in a 'black hole' – where the general sense of self-esteem or self-worth has dropped precipitously and where the individual views the future in a pessimistic way. More importantly, there are a number of clear physical symptoms – the individual has a profound lack of energy that may make it difficult for them to get out of bed, even to have a shower or bath. They lose the light in their eyes. Their concentration is impaired and they feel that their brain is

become angry and even aggressive. Spike Milligan (who suffered Bipolar I disorder) was occasionally hospitalised for trying to take an axe to his neighbours.

Lawyers, a profession a risk

In 2007, Australian lawyers were identified in a Beaton Consulting survey as occupying the number one position in terms of rates of depression among professionals – although it should be noted that their sibling rivals (doctors) were not included

“In 2007, Australian lawyers were identified ... as occupying the number one position in terms of rates of depression among professionals.”

the rest of medicine. To use an analogy: if an individual consulted a general practitioner because they were breathless, it would not be helpful to the patient to be told that they had 'clinical breathlessness' and to be prescribed a 'universal' (or non-specific) treatment. The patient would want to know whether they had asthma, pneumonia or a pulmonary embolus – for then the treatment (for example, a bronchodilator, an antibiotic or an anticoagulant respectively) would be rational in addressing the putative cause.

Thus, our Black Dog Institute assessment and treatment model works to the following assumptions. First, that there are *differing types of bipolar and unipolar disorders* – some being categorical disease entities reflecting perturbed biological processes, while others are depressive disorders more reflecting psychosocial causes. Second, that these separate conditions can be *clinically differentiated by more sophisticated and logical assessment*. Third, that such differentiation is meaningful in that *valid treatment requires adopting a therapeutic approach* (be that a drug, psychotherapy or counselling approach) that actually addresses the causal factor.

Earlier, I mentioned melancholic depres-

just chugging along. They are often physically slowed, their voice sounds monotonous and they lack all spark and creativity. On the other hand, some sufferers can have intense periods of agitation – where they need to pace up and down, wring their hands and are preoccupied about what is going to become of them. These are incredibly painful states. The physicality of melancholic depression is addressed in Matthew Johnstone's illustrations.

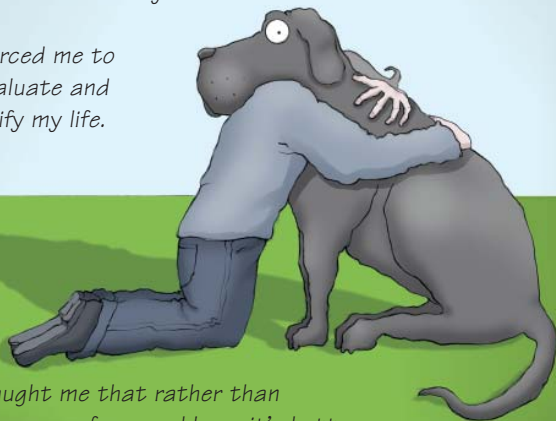
So, what does a 'high' feel like? These states are the converse of melancholic depression. Thus, rather than low mood and low energy, the individual is now euphoric and confident, highly energetic and 'wired'. They are bright-eyed, talkative, on the go and super confident, while day-to-day anxieties disappear. The individual feels more creative, needs less sleep but doesn't feel tired. Libido is increased, as is spending, and frequently people in this state can make financial decisions that they regret later and which might even risk financial ruin. At lowish levels, creativity is genuinely increased and people are often far more efficient at work. At higher levels, creative profundity can become pseudo-profundity, while during a psychotic state, some individuals can

in the questionnaire. So, why might lawyers have such high rates? A number of explanations can be offered. Clearly, the practice of law is highly stressful, where there is a strong need to get 'things right' and avoid errors. But stress is stress, not depression. Depression requires a loss of one's self-esteem. For those who invest their self-esteem in work (and perfectionism and pride in work are common characteristics of lawyers), any perceived slight to their self-esteem will provide a risk.

Opportunities are many – court cases can be lost, promotions and demotions in legal firms are public events, and work performance in general across other parameters is also commonly open to peer review. It might be said that lawyers are trained to be negative or at least cautious, while the 'happiness literature' informs us that to be happy (in the eudemonic well-being sense) requires being open to new experiences and accepting of people. In practice, lawyers are trained to be judges, and 'negativity' is associated with succeeding in the law. Legal practice – especially for junior lawyers – does not encourage autonomy of decision making – which can then lead to a mental set of 'learned helplessness' (a feeling that the individual's

I wouldn't say that I am grateful for having Black Dog in my life but what I have lost to him, I gained in other ways.

He forced me to re-evaluate and simplify my life.



He taught me that rather than running away from problems it's better to acknowledge and even embrace them.

Black Dog may always be a part of my life. But I've learnt that with patience, humour, knowledge and discipline even the worst Black Dog can be made to heel.



capacity to control issues is limited – and so driving depression).

The professional stress in turn can lead to high alcohol intake and alcohol can be depressogenic at certain levels. In the Beaton survey, one-third of the lawyers stated that they used alcohol to manage feelings. And for women who feel they must adopt the male competitive model to 'succeed' in the legal profession – and this might mean delaying or abandoning motherhood – the risk of depression is high. For lawyers who develop depres-

sion, the legal 'culture' is not conducive to discussion with peers or to seeking professional help, nor are there practices in place that are as advanced as those introduced by medical boards to deal with similar problems in the medical profession over the last two decades.

The legal profession attracts perfectionists, and rewards and advances perfectionism. While perfectionism is often associated with a lowered risk of depression (as the individual imposes control over their lives), once a perfectionistic

individual feels demeaned or humiliated, they can deconstruct rapidly as they choose between their limited dichotomised responses ('break through or break'). Depression and suicide are then a real risk. Such risks in a diathesis-stress model (linking personality style and work culture) can be reduced by putting into place corrective systems and support mechanisms within the workplace. 'Are we doing enough within our firm to assist our staff?' is the question that managing partners should be asking themselves. □

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