THYROID FLYER

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Inside

Psychological Aspects

Editorial

By **Christopher McDermott**

Welcome to the third and last edition of the Thyroid Flyer for 2006. Robyn Koumourou, our current editor, has compiled another edition full of interesting reading – this time on the psychological aspects of thyroid conditions, making it an appropriate complement to the last bumper edition on diet and thyroid. This may well be Robyn's last edition for a while. She will be having a very well-earned rest now from nearly all her volunteer contributions to Thyroid Australia. We wish her all the best.

Another retirement from our committee at this time is Alun Stevens. A founding member of Thyroid Australia, with his wife Megan, Alun also is very deserving of a break. Alun has been a very important contributor – setting up and maintaining our website, producing and editing thyroid newsletters, creating and presenting our support volunteer training programs, giving public presentations, keeping the finances in order and acting as company secretary. Also, he has answered many emails to many inquirers on the more technical aspects of thyroid conditions, treatments and being something of an expert in the statistical side of blood tests and other scientific aspects of thyroid conditions.

We had our annual general meeting on 26 November at the Waverley office. We have some new committee members nominating and I am looking forward to introducing the new committee early next year. More on that in the next newsletter. *Editorial continued pg 6.*

Christmas Break

Thyroid Australia will be closed from December 15th to January 26th. The office will reopen on Monday January 29th.

The Thyroid and the Mind and Emotions/ Thyroid Dysfunction and Mental Disorders

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The Thyroid and the Mind and Emotions

Summary of an address to the Kitchener-Waterloo Area Chapter, October 27 1984.

The psychiatric disturbances which accompany hyperthyroidism and hypothyroidism, the two commonest thyroid disorders, mimic mental illness. People with an overactive thyroid may exhibit marked anxiety and tension, emotional lability, impatience and irritability, distractible overactivity, exaggerated sensitivity to noise, and fluctuating depression with sadness and problems with sleep and the appetite. In extreme cases, they may appear schizophrenic, losing touch with reality and becoming delirious or hallucinating. An underactive thyroid can lead to progressive loss of interest and initiative, slowing of mental processes, poor memory for recent events, fading of the personality's colour and vivacity, general intellectual deterioration, depression with a paranoid flavour, and eventually, if not checked, to dementia and permanent harmful effects on the brain. In instances of each condition, some persons have been wrongly diagnosed, hospitalized for months, and treated unsuccessfully for psychosis.

Detection of the thyroid problem is complicated by the fact that everyone feels anxiety and tension to some degree, that many thyroid symptoms are similar to those of other diseases, and that hypothyroidism in particular often develops insidiously over a considerable time. But the results of overlooking the thyroid can be serious. It is very important for the physician to explore fully and give the tests for thyroid dysfunction, which today are relatively simple. When effective thyroid treatment is begun, the general response is quite favorable. Vitality returns and the mental processes become efficient again. If there is a residue of emotional difficulties, it may be related not to the thyroid gland but to other aspects of life.

The question arises: since thyroid hormone therapy is so rewarding for patients who have depression associated with a malfunctioning thyroid, would it also benefit those who have normal thyroid function? The answer is not yet clear, though it has helped some who did not respond to anti-depressants.

Nor is the relationship clear between stress and the thyroid. The number of people who cite unusually stressful experiences before the onset of hyperthyroidism seems to bear out the theory of stress as a precipitating factor. While others can come through the same upheavals without developing thyroid disease, some perhaps are predisposed to it. On the other hand, it can be argued that the illness itself, before its symptoms are manifested, is contributing to the situation of stress.

The physician must also be careful to check the thyroid in cases where psychiatric medications must be taken over a long period. Lithium, the drug commonly used to stabilize the moods and increase the efficiency of manic-depressives, can cause hypothyroidism, particularly in middle-aged women who are the most susceptible to this trouble; the hypothyroidism in its turn can produce depression, the very problem that the treatment was intended to relieve.

Thyroid Dysfunction and Mental Disorders

Summary of an address to the Metropolitan Toronto Chapter, June 11, 1984.

The relationship between psychiatry and thyroid dysfunction has attracted a good deal of attention for the following reasons:

1. Thyroid disorders, such as hyperthyroidism or hypothyroidism, can be accompanied by prominent mental abnormalities.
2. Thyroid hormones have been used in the treatment of certain psychiatric conditions.
3. Some drugs used for the treatment of mental illness can have an effect on the thyroid gland.

Hyperthyroidism

Attention has been directed to the possible role of stress or emotional disturbance in precipitating hyperthyroidism. Although hyperthyroidism may follow some emotional upheaval or stressful event, the possibility exists that the emotional upheaval prior to the illness may have been the by-product of the early phase of thyroid hyperactivity itself before the complete picture of the illness becomes manifested. Similarly, the psychological constitution of those who develop the illness has been extensively studied, but with no good consensus between various personality descriptions given. I believe the role of personality factors has been overemphasized. Psychological disturbances are quite common with thyroid hyperactivity and can be part of the early picture:

- marked anxiety and tension
- emotional lability
- irritability and impatience
- distractible overactivity
- exaggerated sensitivity to noise
- fluctuating depression

More serious mental disturbances which used to accompany "thyroid crisis", such as acute psychotic episodes, delirium and fever are rarely seen these days as a result of the improved detection of the illness and availability of effective treatment.

In general, the psychological disturbances show satisfactory resolution with adequate treatment of the thyroid hyperactivity.

Hypothyroidism

Since hypothyroidism usually develops slowly, and the early complaints are frequently minor, vague and diffuse in nature, it is not surprising that the diagnosis is often overlooked. However, the physical changes that accompany the illness are characteristic: dry, rough skin; pale and puffy complexion; loss of hair; change in voice; decreased appetite, etc.

Psychological symptoms are common and well manifested by the time the patient seeks medical advice. Not infrequently, psychological disturbances are the main complaints that bring hypothyroid patients to the psychiatrist first:

- marked slowing of all mental processes
- progressive loss of initiative and interest
- memory difficulties
- thinking is easily muddled
- general intellectual deterioration
- depression with paranoid flavour
- organic psychosis

In severe, untreated cases, dementia may be the ultimate outcome. This underscores the importance of early detection and treatment.

Use of Thyroid Hormones in Treatment of Mental Illness

It is claimed that in the treatment of depression not related to any thyroid disturbance the addition of thyroxine may hasten and augment the effects of antidepressant drugs. Thyroxine was also found to be beneficial in the treatment of a rare condition call periodic catatonia in which the patient's condition alternates periodically between states of apathy and immobility and marked excitement.

Effects of Psychiatric Drugs on the Thyroid Gland

Lithium, a natural element drug used successfully to treat manic-depressive illness and prevent relapse, was found to produce a state of hypothyroidism in some patients. This side effect is not universal and happens only after long-term use. Middle-aged women seem to be more vulnerable to this complication. This underscores the importance of regular monitoring of thyroid function during long-term lithium therapy. In conclusion, disturbance of thyroid function may be accompanied by psychological disturbances which can mimic other psychiatric syndromes. Hence, early detection and treatment of the thyroid disturbance, as well as appropriate attention to the emotional and psychological condition of the patient, cannot be overemphasized.

PSYCHOLOGICAL SYMPTOMS AND THYROID DISEASE

People with disorders of the thyroid gland very often have psychological problems as well as physical symptoms. The common problems they notice are in the emotional and intellectual sides of life.

Emotional problems

Often people with thyroid disease feel more emotional than they used to, their moods changing rapidly and unpredictably. Sometimes one particular mood is more prominent and persistent than another. Common emotional problems are anxiety - a feeling of nervousness, with butterflies, heart racing, trembling, sleep difficulties; irritability - snappiness or short-temper which people often call 'moodiness'; and depression - low mood and difficulty enjoying things, perhaps with tearfulness, loss of appetite, and disturbed sleep or other symptoms.

Intellectual problems

Difficulties with concentration and day-to-day memory may be the first symptoms notices, along with a decline in interest and mental alertness. These symptoms can cause older people to worry about brain failure (dementia) but in fact they are rarely severe and respond to treatment of the thyroid disease.

What causes the symptoms?

The first and most obvious cause of emotional problems in a patient with thyroid disease is abnormalities of thyroid hormone levels. Hyperthyroidism may cause anxiety, irritability and emotionalism (see pamphlet 5 "Hyperthyroidism due to Graves' Disease") while hypothyroidism more often causes mental slowing and memory problems (see pamphlet 3 "Hypothyroidism").

Rapid fluctuations in thyroid hormone levels seem particularly prone to unsettle people's emotions. This can happen in some patients with thyrotoxicosis in which the underlying cause of the condition appears to vary in intensity, with the result that it is hard to keep the dose of medical treatment appropriate to changing requirements. Doctors often deal with this situation by a 'block and replace' approach in which a large enough dose of antithyroid drug is given to prevent any appreciable thyroid production, with a topping up dose of thyroxine sufficient to supply the patient's needs. This ensures stability of the thyroid condition and allows emotional distress to settle.

Sometimes treatment can cause psychological symptoms as one of its side-effects. The antithyroid drugs or radioiodine do not seem to cause such difficulties, which are mainly encountered if steroids are prescribed. In addition, some people find that beta blockers make them feel slowed down, 'muzzy' or mentally less alert.

Apart from physical causes, thyroid disease may produce emotional problems because of the meaning it has for people, or the effect it has on their day-to-day lives. For example changes in appearance (especially due to eye disease or weight change) may damage self-esteem or lead to awkward stares or questions.

Stresses in other areas of life can of course cause psychological symptoms which may be more pronounced or take longer to settle down in somebody who is also suffering from thyroid disease.

What about treatment?

In the great majority of cases, psychological symptoms improve as the thyroid disorder is brought under control by treatment. Improvement may not be rapid, and it is common for people to feel 'not themselves' emotionally and mentally for some time after their blood tests return to normal. This can be best helped by open discussion with your doctor, or if necessary, a specialist with experience in dealing with thyroid disease, rather than bottling up fears inside yourself.

Occasionally, anxiety or depression require treatment in their own right, and such treatment can help improve symptoms even when the thyroid disorder is not yet fully controlled. Although the cause of the symptoms may be a physical one [thyroid disease], non-drug treatments such as relaxation or short-term psychotherapy may be helpful. Drugs such as antidepressants, which are non-addictive, may be tried in more severe or persistent cases.

Recovery and the long-term

It has been suggested that emotional problems may cause thyroid disease, or aggravate it when it already exists but there is no firm evidence to support that idea. In fact for all types of thyroid disease the outlook is good, even if psychological symptoms initially seem to take a long time to settle.

Sometimes people forget to take their thyroid medication, or lose motivation when it comes to tablet-taking or attending clinics. This of course can have an impact on the outcome of the disorder.

If you have thyroid disease, you should not feel awkward or embarrassed about discussing psychological symptoms with your doctor. They are an important part of the experience of illness, not a side-issue or a sign of weakness. Do not be afraid to mention any difficulties you have with taking treatment, and ask as many questions as you need to in order to understand what is happening to you.

If symptoms are especially severe, or if they persist even after a fair trial of thyroid treatment, then specialist help may be beneficial. A psychiatrist or a clinical psychologist with expertise in the problems associated with physical illness will be well placed to help, and you should discuss referral either with your general practitioner or the hospital.

What is wrong with me? I am not myself anymore

By **Jessica Somerville Ruffolo, M.A. and Robert A. Stern, Ph.D.**

Have you felt tense and irritable? Have you had trouble concentrating?

You are not alone. If you have ever wondered whether your change in mood or thinking problems might be due to your Graves' disease, keep reading. We are going to describe the emotional, behavioral and cognitive changes that may result from having Graves' disease.

Graves' related emotional and behavioral symptoms

Changes in emotion and behavior are very common in patients with Graves' disease. The changes may include emotional liability, nervousness, restlessness, irritability, fatigue and insomnia. These symptoms are very similar to those experienced by people with anxiety disorder or clinical depression. These changes are often what lead patients to treatment in the first place. However, as you can imagine, it is easy to misapply these symptoms to a primary" psychiatric illness. Too often in fact, patients with Graves' are misdiagnosed because of the similarity in symptoms between Graves' and psychiatric disorders. (Refer to Table 1) This can result in inappropriate treatment. Sometimes it can also result in a further worsening of Graves' because it delays a true diagnosis and appropriate treatment. Examples of common misdiagnoses include generalized anxiety disorder, panic disorder, social phobia or depression. The symptoms of these disorders may be very similar to those of Graves' but the cause is very different. Some treatments of the presenting symptoms may be attempted such as medication and relaxation techniques. The primary treatments of the disease itself with anti-thyroid medication, radioactive iodine treatment or surgery are necessary in the patient with Graves' disease.

Figuring out the cause of the symptoms can be further complicated when a patient already has a primary psychiatric diagnosis before the development of Graves'. The emotional and behavioral symptoms of Graves' disease may keep other patients from seeking help in the first place and receiving treatment. Many people find themselves embarrassed by what they may consider "personal problems". They hope the symptoms will eventually just go away. Graves' disease will not remit without treatment. The following story could be an example. It is based on several stories of our patients:

A busy 35-year-old working mother of two children began feeling nervous, with heart palpitations, a jittery feeling and poor concentration. "It's only stress and anxiety", she told herself. "I can handle this." Months passed with no relief. Her symptoms worsened and she felt even more out of control. Finally she "gave in". A psychologist diagnosed her with anxiety and treated her with relaxation techniques and talk therapy. It wasn't until the symptoms worsened further that she told her family doctor of her state. This doctor put her on anti-anxiety medication. This medicine only minimally improved her symptoms and she began feeling completely out of control and "crazy." Finally, her physician did a TSH test and discovered the hyperthyroidism. This was after many months had passed from the beginning of her symptoms. This woman and her health care providers made the very common mistake of viewing her emotional, behavioral and cognitive symptoms as being caused by psychological or psychiatric factors rather than to the real source, Graves' disease.

Many or most people do receive treatment in a timely fashion. The rare condition of "thyroid storm" can occur when extremely high levels of thyroid hormone are allowed to build up in the system. In addition to the other medical problems associated with thyroid storm, this condition can also result in psychosis and profound agitation. Elderly patients with untreated Graves' disease may present as more depressed, apathetic and slowed down. This is quite different from the anxious and irritable presentation of younger people with Graves'. A person usually feels sad or anxious with the typical "psychiatric" depression or anxiety. These emotions are not always reported in Graves' disease. You may feel as if you have all the symptoms of anxiety or depression, such as palpitations, being shaky, or feeling irritable or fatigued. You may not, however, necessarily feel the emotions of being anxious or sad. The table below is an illustration of this point. It shows the shared symptoms and those that are different between Graves' disease and a primary anxiety disorder. Many of these shared signs and symptoms are likely due to excess adrenaline, resulting in "fight or flight" symptoms. Abnormally high thyroid levels cause this. Your body is then constantly in a state of increased alertness and high energy output. It is also possible, however, that the changes in thyroid hormone levels directly affect how the brain is functioning. In addition, the autoimmune effects of Graves' may also directly affect the brain, causing some of these symptoms. Researchers are trying to understand these mechanisms further.

Table 1. Comparison of the similarities and differences among Graves' disease and anxiety

Graves' only	Anxiety only	Both Graves' and Anxiety
Goiter	Anxious or sad mood	Shakiness
Eye protrusion	Fear of dying	Palpitations
Heat intolerance	Dizziness	Sweating
Warm moist skin	Unreality	Decreased sleep
Increased appetite	Chest pain	Shortness of breath
Weight loss	Faintness	Nervousness
Amenorrhea or impotence		Fatigue
Hyperactive reflexes		Irritability
Muscle wasting		Diminished concentration

"Neuropsychiatric" symptoms reported by patients with Graves'

Our group conducted a survey of the members of the National Graves' Disease Foundation in March 1992. Bulletin #43, which contains the results of this survey and the full scientific journal article (*Journal of Neuropsychiatry and ClinicalNeurosciences*, 1996; 8:181-185), may be purchased from NGDF. 137 patients with Graves' disease completed a questionnaire pertaining to neuropsychiatric complaints. The neuropsychiatric impairments were clinically acknowledged to be common at the time of this survey. The prevalence of these symptoms was unknown because no studies had been conducted addressing this issue. Table 2 lists the percentages of Graves' patients who reported having these symptoms while they were hyperthyroid. The results also indicated that Graves' patients sometimes went for very long periods of time before seeking treatment. 23% of the survey respondents reported waiting 3 to 6 months before seeking help for their symptoms. Over 35% waited over six months! It took more than 3 months for another 35% of the patients to receive an accurate diagnosis after they sought treatment! We expected the survey respondents to report that their overall functioning was significantly worse while they were hyperthyroid, when compared to the two years prior to the onset of their symptoms. Although they reported that their functioning did improve somewhat once they received treatment for their Graves', it was still much worse when compared to how they were functioning prior to the onset of their Graves' symptoms. This may indicate that many patients with Graves' disease do not feel that they return to their baseline level of functioning even after treatment returns their thyroid hormone levels to the normal range. Two similar survey studies of Graves' patients in other countries were published after our survey results became public. Both of these studies confirmed the findings of our study. They also showed that neuropsychiatric symptoms are very common in Graves' patients and may linger on for some time after treatment. The reasons for the prolonged symptoms are not currently well understood. We also do not know the reason why some Graves' patients have more of these emotional and behavioral changes than others do. There are some patients who seem to have very few of these complaints or none at all. Our group and others are currently examining these important questions.

Table 2. Percentages of Graves' patients reporting symptoms when hyperthyroid

Symptom	% of people with the symptom	Symptom	% of people with the symptom
Irritability	78.1	Easily startled	52.9
Visible shakiness (especially hands)	77.4	Significant decrease in social activity	45.6
Feeling hot most of the time	73.7	Feelings of being out of control	44.5
Anxiety	72.3	Hopelessness	42.6
Inability to sleep	66.4	Sadness	41.9
Increased fatigue/weakness	65.7	Loss of sense of humor	41.2
Sensation of shakiness inside but not visible	65.4	Decreased sexual desire	40.1
Loss of more than 5 lb. in 3 months	62.8	Slowed thinking ability	39.7
Trouble breathing/shortness of breath	59.6	Loss of interest in the things that formerly gave you pleasure	39.0
Change in hair or skin texture	57.4	Chest pain	37.5
Anger	55.9	Not being able to "connect" with others	33.8
Increased crying	55.1	Changes in menstrual cycle	33.8
Inability to perform some daily tasks	50.0		
Hot or cold flashes	47.8		
Tired all the time	47.4		

"Neurocognitive" changes related to Graves'

Graves' patients also commonly report a variety of "neurocognitive" complaints. The most frequent are poor attention, diminished concentration and memory problems. The results of the few existing scientific studies indicate subtle deficits in concentration, memory and reaction time in hyperthyroid Graves' patients. There is also evidence to suggest that Graves' disease may reduce "executive" functions, which control higher-order functions of the brain. These functions include:

- problem solving — being able to consider many options and alternatives and being flexible
- conceptualization — being able to see the "big" picture
- planning and organization

These executive functions are thought to involve the front parts of the brain (frontal lobes) and their connections with the deeper, inside parts of the brain. A recent study used a technique known as Magnetic Resonance Spectroscopy which examines brain activity. This study indicated that in acutely thyrotoxic Graves' patients, there was a reduction in the metabolism in the frontal lobes, particularly on the right side. Most of these neurocognitive changes improve after successful treatment of Graves' disease according to self-report and objective measures. Some cognitive deficits may not improve so

easily in patients who have had untreated Graves' for a long period of time. Comprehensive, longitudinal studies need to be done. This type of longitudinal research would follow these Graves' patients over time to assess any changes in brain functioning. Our group is currently investigating the neuropsychiatric and neurocognitive changes associated with acute hyperthyroid Graves' disease. We are also investigating whether there are changes in the brains of Graves' patients using Single Photon Emission Computed Tomography (SPECT). This diagnostic tool measures how much blood goes to different areas of the brain. Preliminary analysis of the data from this study suggests that there is reduced frontal lobe functioning in some hyperthyroid Graves' patients, as seen on both neurocognitive testing and with SPECT. It should be noted, however, that this study is not yet complete and much more research in this area is needed.

Our research group is evaluating whether any brain changes or neurocognitive problems remain following treatment of the disease. Graves' disease is an autoimmune disorder. The thyroid gland and the eyes are known to be autoimmune sites. There is some suspicion that another autoimmune site may be the brain. This is why we are investigating whether changes in the brain may continue even following treatment of the thyroid gland. We are also conducting another study aimed to answer the question: "Is the autoimmune thyroid disorder of Graves' different from other thyroid disorders?" We are comparing treated Graves' patients to treated hypothyroid patients in this study. We are using the same comprehensive battery of neuropsychiatric and neurocognitive measures as in the first study. Our results will be shared with you.

Quality of life changes

Did you recognize yourself or your loved one in the previous descriptions? Have you found that your life has been somewhat or dramatically altered by Graves'? Again, you are not alone. Graves' patients and family members can adapt to personality, emotional, behavioral and cognitive changes that are experienced by many. This can be very stressful for everyone and can dramatically affect the support system for Graves' patients. It may lead to marital stress and conflict.

This is described in the NGDF Bulletin #38, "An Open Letter to the Husbands of Graves' Disease Patients":

"In a lot of ways my wife and I were fortunate. She was diagnosed with Graves' disease after approximately nine months; at least that is the closest she and I can pinpoint when she began to first experience the symptoms we now associate with Graves'. During that time, however, while I always knew my wife loved me, frequently who I was married to was not my wife. One aspect was the mood swings, the unexpected outbursts of anger and accusation, the unexplainable crying. This took the most work for me to deal with emotionally."

It is so important to realize that what you are going through may be very common for individuals with Graves' disease and their loved ones. These symptoms may be part of the physical disease that affects your thyroid, your eyes, and possibly your brain. Treatment of the disease is essential, though as already mentioned, some symptoms may still remain for some time following the point your doctor tells you that your thyroid hormone levels are "normal." Feeling frustrated about this is also expected. Sometimes increasing your support, whether through friends and family, or by attending a support group, or by engaging in counseling or psychotherapy, may help you to cope with your feelings. People tend to dismiss their worries or concerns, especially when their cause is misunderstood or not appreciated. The following quote from a respondent in our survey illustrates this very point:

"Before I was diagnosed I felt as though I was losing my mind. I couldn't get along well with others and my marriage was affected. I would go to the family doctor and he would say, 'Oh, this is normal for a working mother of three.' I lost all self-confidence and worried a lot. I thought I had cancer or some other life-threatening disease. When I found a doctor that I was able to talk to and she understood, it was a wonderful moment."

This excerpt from the NGDF message is taken from a post by the board's facilitator, Jake George:

We understand. We have been there... You have every reason to feel the way you do. I know how you feel. I know it will get better. I know that sometimes I just have to stop what I am doing and take a nap. Sometimes I have to just get up and go home from work. It does get better but sometimes we just need to rest, vent and assorted other things. So you see we do understand. If your friends or family do not understand just tell them you need a nap, hot bath, book or whatever works for you. You will get better. I know you will. We are only a click away and you are never alone.

Ms. Ruffolo is a doctoral student specializing in Clinical Neuropsychology at the University of Rhode Island. Dr. Stern is Associate Professor of Psychiatry and Neurology at Brown Medical School and Director of Neuropsychology at Rhode Island Hospital in Providence. He is also a member of the NGDF Board of Advisors.

Editorial continued:

Our annual report for 2005-06 was distributed to all members recently. We have had another successful year. Demand for the support and help we provide continues to remain strong. We have over 800 members including more than 40 volunteers covering telephone support, office help, support group convenors and other tasks. Although full access is limited to members, our website attracts around 400 visitors every day.

During 2006 we increased the hours of employment of our office manager to half-time and employed Brenda Stocks in this position. This has made an enormous difference to the quality of service we have been able to provide.

Thyroid Australia has finished 2005-06 with a small surplus and a healthy bank balance.

I would like to thank Brenda and the committee of Thyroid Australia, as well as all our volunteers, for another successful year for the organisation.

Our success is measured by the many positive messages we get back from our members and others in the community who are so appreciative of the help and support we provide.

I wish you all a happy Christmas and hope you remain well over the summer break.

CMcD

Depression and Thyroid Illness

By **Lawrence C. Wood, M.D., F.A.C.P.**

Introduction

Depression may be the first sign of an overactive or underactive thyroid. The nervousness, anxiety, and hyperactivity of hyperthyroidism often interfere with a person's ability to function in normal daily activities. Both anxiety and depression can be severe, but should improve once the hyperthyroidism is recognized and treated.

Depression is more commonly associated with hypothyroidism with its fatigue, mental dullness and lethargy leading to depression which is often profound and severe enough that a physician may mistakenly treat the patient first for depression without testing for underlying hypothyroidism. Since most hypothyroidism begins after age fifty, the symptoms are often attributed to aging, menopause and/or depression.

Postpartum Depression

Approximately one in twenty women experience a change in thyroid function following pregnancy. Since this is a time when the responsibilities of the young mother are considerable, she may attribute the fatigue and emotional symptoms as a natural result of her increased duties and lack of sleep. Some physicians have suggested, however, that every young mother who experiences depression should have a TSH test to be sure her thyroid function is normal.

Bipolar Mood Disorders and Thyroid Disease

Bipolar is a relatively new term that psychiatrists are using to describe individuals whose emotions tend to swing from highs to lows, elation to the blues. A subgroup of this population experience rapid cycling, meaning that they have at least four major highs and lows per year. Studies of patients with rapid cycling bipolar disorder, (80% of whom are women) have shown that 25-50% have evidence of thyroid deficiency. Some feel well, and their only evidence of thyroid failure is an increased level of TSH in their blood. Others are clearly hypothyroid.

Lithium: A problem for some patients

Physicians have prescribed lithium in the treatment of depression for years. It has a low incidence of side effects and a high success rate in treating depression, especially bipolar disorders including the rapid cycling described above.

Unfortunately, in individuals with an underlying tendency toward thyroid dysfunction, lithium may cause hypothyroidism. Since most physicians are aware of this relationship, it is now common for a physician to first check the serum TSH levels of a patient before prescribing lithium, repeating the thyroid test periodically while the patient is on the medication.

Are you at risk?

Not all individuals with depression have a thyroid problem. Nevertheless, because thyroid dysfunction can be so difficult to recognize yet so responsive to treatment, most physicians will order an initial serum TSH test to evaluate thyroid function.

You are at increased risk if you or a close relative has had a thyroid problem. Your risk is also increased if you have a related autoimmune condition such as diabetes requiring insulin treatment, pernicious anemia, or the white skin spots of vitiligo. You are also more likely to develop thyroid dysfunction if you or a close relative have had prematurely gray hair (one gray hair before thirty) or any degree of ambidexterity or left-handedness.

But why risk missing a thyroid problem if you are depressed? Discuss these concerns with your physicians and be sure that your TSH has been checked before you are treated for depression.

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Pamphlets on Postpartum Thyroiditis are available from the office on request. This brochure contains important informative on the development of thyroid conditions during and after pregnancy, including symptoms, diagnosis and treatments.

Members Story

Depression, CFS or Thyroid Dysfunction?

A Member's Story on Depression: written in 1997, prior to thyroid hormone therapy. After suffering with severe depression from her early 20's, she was finally diagnosed with Graves' disease, some 30 years later. She was treated with RAI, but unfortunately following this she developed an underactive thyroid gland and this was overlooked. She was then diagnosed with Chronic Fatigue Syndrome (CFS) and suffered a further 6 years until her underactive thyroid condition was discovered and treated appropriately. Today, she is virtually free of her CFS, and her debilitating depression has never returned.

I've been diagnosed as a 'manic depressive'. The basic cause of my depression is a chemical imbalance in my brain, for which I take medication. I also have Chronic Fatigue Syndrome, as well as an unstable thyroid gland. When I'm on the depressive side, I'm not able to think my way out of it. All I want is to be loved. Anything hurtful, or causing fear or guilt, or stress or mess, just magnifies the depression, with its self-condemnation. I have no positive emotions - just hopelessness and self-loathing. And sometimes my responses seem quite contradictory.

I'm afraid to tell anyone how I'm really feeling when I'm depressed, because I fear (and know) most people won't understand. I've learned this through experience. A well meaning lecture, from someone who lacks insight or understanding, makes me feel even worse, and more of a failure - even suicidal. Yet occasionally because of circumstances, out of integrity, it sometimes seems necessary to explain to another person where I'm at - which may turn out to be a big mistake. My explanations seem to make things even worse for myself. Perhaps because my thinking is so slow when I'm depressed, I can't think of the accurate thing to say as someone loads me with advice. My own honesty can bring about painful suggestions from others - adding to depression.

Which comes first - fear (and guilt) or depression? I'm not absolutely sure. But I suspect depression comes first, because I'm not a fearful person when I'm free of depression - even if circumstances cause pain. When I'm depressed, I feel incapable of adequately dealing with fear.

Where does depression come from? Most of the time I don't know. For a period of time I wake up in the morning feeling immobilized and overwhelmed by despair. Sometimes the pain of depression is so intense that my whole body shakes, and I want to be sick. And my mind experiences such self-hatred that death is the only acceptable pleasurable thought. I long to feel loved, but no love that I ache for can penetrate me - not even my close family. I can't feel God - He's nowhere - so my heart says. And the human love and touch I crave to feel often has no power to seem real. Yet touch seems to be the only thing that has any potential for some healing, however small.

At other times I'm aware of a physical origin - when I'm hungry, I feel a sudden, sharp discomfort in my stomach, and I seem to feel the depression rising from my stomach to my head. I can't stop it. Food sometimes helps then - if I can swallow it. I have to be careful with my blood sugar level.

Sometimes when I'm mildly depressed, circumstances intensify depression - usually something like fear of control by another person. Fear and guilt become magnified in my mind in relation to this person. Then I've 'lost it'. I freeze, and I can't think how to answer. Or the pain of disappointment or loss cuts into me until it becomes depression.

But generally, it's as if 'someone' suddenly 'flicks' a switch - I'm okay for a period, until the switch is 'flicked' the opposite way again for no apparent reason - leaving me in 'dull mode' that can be blown into despairing darkness by the smallest breath, that no positive thinking, or crying out to God can penetrate. Counselling makes no difference then. I gradually creep upward. An adrenalin kick might make me feel good for 5 minutes, or an hour, or a day - what joy!

Or depression seems to be set off, and then magnified by some subtle remembrance that I can't identify - a smell, a movement, a sound, the inflection of a voice. I remember, one day I was in the newsagents. I was browsing through some magazines. Suddenly I felt my stomach turn and then my mind was filled with black pain. Did one of my senses glimpse something from the past? I have no idea what it may have been. I've read that people who are depressed like me, have very finely-tuned senses to stimuli that causes them pain - which increases the likelihood of depression. I know I have heightened senses. I often hear, and smell things before other people - I have been laughed at initially for 'making things up' - until later.

I'm conscious of depression always hovering there, ready to 'get' me. The deeper and more prolonged a depression, with its mental, physical and emotional pain, the longer it takes to subside. Fighting depression or trying to take 'good advice' adds to the pain, as it usually ends in failure - arousing more guilt for maybe not trying hard enough, to cause further depression.

Unless someone has experienced this kind of recurring depression, they have no concept of how difficult it is to function normally with every day living, let alone trying to be an encouraging supporter &/or leader. It creates enormous stress and drain on energy, battling negative thoughts, and sluggish, impaired concentration, as well as using huge amounts of this energy to temporarily appear to others to be normal and cheerful and warmhearted - to overcome all the false physical 'nerve signals' that the brain sends out. A doctor recently told me that depression is a major factor contributing to Chronic Fatigue Syndrome, or is it the other way around? All I know is that depression saps energy.

The deeper the depression, the deeper the fear of disapproval and rejection, and my ability/inability to perform adequately or acceptably. There is fear at times that maybe my imagined purpose in life is just a delusion, and I become convinced I have no ability to achieve, and there is good reason to believe that no-one else might believe in me - despite my reason suggesting otherwise because of past accomplishments - I try to live by faith and reason, not feelings.

IT'S MORNING....Chronic Fatigue Syndrome...

This morning I woke up feeling no enthusiasm for life. What could I look forward to? Anything? Ah! My spirits lifted. The newspaper was waiting for me on the front lawn! That thought brought enough stimulation to my dull and heavy body and mind to get out of bed. Something different to think about! But would my legs take me to the front lawn? Then what next? Yes! Ring a friend. I've been thinking about inviting her over for lunch for weeks. I feel excitement stirring in me - I begin to feel much better. But no! My Chronic Fatigue framework tells me the price of this pleasure is too high - the next few weeks' plans are already at the limit of my coping. Added activity will aggravate CFS, killing enthusiasm, igniting depression. I have to put aside my 'self encouragement', and fulfilling ideas. What is there to look forward to today? Perhaps I should read the paper every day. And have as quiet time every day until I get a severe headache - that seems to happen most days anyway, and I feel so disappointed and frustrated, because I can't read for long, or study, or finish praying as I would like to - sometimes I don't even start in case I won't have the energy for anything else.

Then my spirit lifts as I look forward to Fridays - seeing my much loved daughter and grand children. Sometimes my depression eases as I think of them. As Friday comes to an end, how disappointed I am. I forget what real exhaustion is until I've spent time with these dear little girls. But I'm not depressed when I'm with them - not yet. Later that day, the amount of physical energy required for this adventure is debilitating. I want to cry from exhaustion and physical pain. And then depression creeps over me. I don't want to tell my daughter. But she knows. I feel as if I'm tied with ropes, with my hands behind my back, standing in a corner - alone. I don't want to stand there forever.

I think having goals, and strategies, and something to 'fight' for keeps me balanced and healthy. If I keep moving forward (slowly, yet noticeably) I'm emotionally better off. Without these things, I feel controlled and helpless. Yet, to counter the good, CFS literally 'chops me off at the knees' for periods of time. Is it because I have become too emotionally involved with something - happy or unhappy? Goal setting and strategies are an important part of me as a person. If anyone (or anything) tries to block or interfere with my goal setting and strategies in a way that I see as negative or destructive, fear and depression are greatly heightened - particularly if I can't fight for what I believe to be an essential element in my ongoing plans.

Sometimes I'm told I'm independent in the way I work. Part of that independence is probably related to my health - I need the freedom to adjust what I do if I feel I'm not coping physically or mentally and I fear the scrutiny of others who don't understand. I need space to move as I need to move, space to be creative - not trying to work or exist in a restricted, controlled environment. I don't think I'm 'driven' as some people suggest, when trying to convince me to behave like a serene phlegmatic - "the only spiritual way" of behaving, according to them. (Well, I was born 'silly' and 'full of beans'. And I became a good 'driver' at a very early age! (even if it was only on a tractor.) I'm a pioneer - I need to move on, to explore what life has to offer. So I keep moving forward - touching other's lives - that eases depression. I go out, and ride more on the high side - giving, loving. However, when I come home I'm in anguish, enveloped in black depression. But no one out there knows.

Antidepressants make no difference to me. My doctors believe the root cause of depression is fundamentally physical. So I take medication for a chemical imbalance, which helps a little. But what has caused this imbalance? Is it in my genes, is it chronic fatigue or is it my thyroid? Where did it all begin?

Even though the inward battle is costly, and seemingly overwhelming at times, I will keep going. I need to know that I'm loved, and that my love is accepted - especially through physical touch - and treated as normal. I deeply value encouragement and challenge, to look forward and achieve. Sometimes it touches the right place in me, and gives me hope. I don't need much praise - just assurance that I'm doing the right thing, and that what I am doing does have value.

I often see my depression as a gift. Does God desire this struggling, and my almost unintelligent prayer? Later, when I look back, I'm amazed. I feel so rich! My depression gives me insight into the pain of others - people of like suffering. How my heart aches for them. They know I understand, and I can reach them in ways that many other people can't. This creates bonds of love, and I feel so rich. I may have walked with much pain in my life, but I think my years on this earth have been uncommonly rich and fulfilling. At night I sometimes dream of walking along a straight and narrow vivid blue or white path through incredibly beautiful countryside, with colourful, fertile farmlands stretching into the distance. I feel overwhelmed at the privilege of being able to see and walk through this scenery. And ahead, there are breath-taking mountains for me to climb - sometimes I am already climbing them. The climb looks impossible. Yet if I turn and look back, I see all the obstacles I have already overcome along the way, and I am encouraged to continue on - no matter how hard the struggle. I like to believe that these dreams are a portrayal of my life - past, present and future. Life is worth living.

Helen 1997

Members Story

A SOLILOQUY FROM A DISILLUSIONED, DISPASSIONATE SUFFERER

– not in silence … MUCH!

I'm not feeling well. I've felt like this before. Strange, tired. A heap of vague symptoms come and go. My voice is low and husky instead of the voice I used to have – feminine and at times, lyrical.

Energy ebbs and wanes. Sometimes I just want to get into bed never to wake up. I'm not depressed like in the 'old days'. It's more of a 'couldn't be bothered'/ numbed out feeling.

My body is not responding to old signals which used to light me up. A look, a smile, and a certain way of walking. Nice hands, words. Nice anything! But nothing happens when I see men these days. There's very little sensation of pleasant experiences. Numb.

I have to make a huge effort to make anything happen these days. I even have to remember how I used to react and fake it. Being *pleased* for someone else's good fortune! Must remember to smile at that or you'll be branded a hard arse … Try and remember how it used to feel when someone nice and sexy kissed you and how your groin would lurch with desire. Remember? It used to happen. Don't forget.

And what about the anger! Little things that totally went past me are now caught up in my anger web and an intolerant, insect-minded being takes over my choices. I am the prowling, hungry spider ready and willing to trap my next hapless victim.

Oh, the poor souls who love me. I have now become their Unanswerable Question. Who IS Mum, these days? But, really – who cares? They didn't appreciate me when I WAS a nice person, so who cares if they don't like who I am today…

And what about the future? What future? Can't see one anywhere. I used to. I'd look forward to good times with people I liked and loved. But now those thoughts don't even begin to appear. I've forgotten how or what to think about the future.

Forgotten. THAT'S a word I use a lot today. I forgot…sorry. What was you name again? Sorry, bad memory. Sorry. Strange, perturbed looks appear on people's faces. (Is this what my mother endured? She was a well-known nutter from way back. Did SHE have thyroid problems at this young age of 50? It would explain a lot about my weird way-out mother as I was growing up).

GP's in denial. Denouncing. Frowning. Vague. Not even an interested female GP? But your blood's normal! You're perfectly fine! We can't help you… Don't try and tell me about that mild hypothyroid crap! It's all a lie cooked up by those bloody alternatives…

Is there anyone in town who can help me? No? Nobody… You have to go to Sydney, back to your old GP who understood the problem. More blood tests. Waiting. More blood tests. Still waiting. Pills. Potions. Powders. I'm still tired. Still forgetting. Still waiting…

BY DEBRA

Member since August 2006

The Beauty of Butterfly Wings

Alone in the darkness
Encased in a plain brown cocoon
I wait here in silence
My heart has no tune

I feel the winds and the rains
And the burning heat of the sun
I'm trapped in this solitude
Am I the only one?

Is there a reason for my plight?
Another who feels the same?
Will my constant struggle and search
All be in vain?

As life goes on along its path
And time brings growth and repair
A seed of faith looks forward in hope
Of a richer life to share

Changes begin to evolve
In my heart and soul and mind
Filtering through my delicate frame
A breath of life I find

New wisdom and strength empower me
I confront my protective shell
A fine small light appears
The shadows to expel

Barriers around me begin to break
As I cease to question why
Instead I spread my colourful wings
And make the choice to fly

I breathe in fresh air as I rise above
And take in all that life brings
Remembering always - from a plain brown cocoon
Comes the beauty of butterfly wings

By RWK 2006©