

Understanding Major Depression and Recovery



What
you need
to know
about this
medical
illness

Major depression is a medical illness that affects thoughts, feelings, behavior, mood, and physical health.



Introduction

Like diabetes and heart disease, major depression is a serious medical illness, and it is quite common. Psychological, biological, environmental, and genetic factors contribute to its development.

For many years, people living with depression and their families were blamed and experienced societal prejudice as a result of their illness, partly because their illness was so poorly understood. During the last few decades, however, scientific research has greatly expanded our understanding and firmly established that mental illnesses like major depression are biologically based brain diseases.

Major depression affects about five to eight percent of the United States' adult population in any 12-month period, which means that, based on the last census, approximately 15 million Americans will have an episode of major depression this year. Depression occurs twice as frequently in women as in men, for reasons that are not fully understood. More than half of those who experience a single episode of depression will continue to have episodes that occur as frequently as once or even twice a year. Without treatment, the frequency as well as the severity of symptoms of depressive illness tend to increase over time.

Major depression is also known as *clinical depression*, *major depressive illness*, *major affective disorder*, and *unipolar mood disorder*. It involves some combination of the following symptoms: depressed mood (sadness), poor concentration, sleep disturbances, fatigue, appetite disturbances, excessive guilt, and even suicidal thoughts. Thus, left untreated, depression can lead to serious impairment in daily functioning and even suicide, which is the eleventh-leading cause of death in the United States. Devastating as this disease may be, it is treatable. The availability of effective treatments and a better understanding of the biological basis for depression may lessen the barriers that can prevent early detection, accurate diagnosis, and the decision to seek medical treatment.

This brochure is intended to answer your questions about depression and give you valuable, accurate information about this illness and how it is treated. Unfortunately, major depression often goes unrecognized and untreated. You may need this information because you suspect you may have depression, or you may want to become knowledgeable because a family member or friend has the disorder.

Major depression is only one form of depressive illness. *Bipolar disorder*, also known as *manic depressive illness*, is a less common form of depression characterized by symptoms such as

mood swings, loss of sleep, extreme “highs,” increased energy and activity, increased risk-taking and poor judgments, feelings of great pleasure or irritability, aggressiveness, and racing, disconnected thoughts as well as “low” periods very similar to those experienced by individuals with depressive illness. A companion to this brochure, *Understanding Bipolar Disorder and Recovery: What you need to know about this medical illness*, is available from NAMI. (See end of booklet for contact information.)

Having a physician make the right distinction between unipolar depression and bipolar depression is critical, since treatments for these two depressive disorders differ. On the one hand, antidepressant treatment (the cornerstone of treatment of unipolar depression) can in some cases activate manic symptoms or even worsen depressive symptoms, including suicidal thinking, in people living with bipolar depression. On the other hand, standard treatments for bipolar disorder (lithium, mood stabilizers, antipsychotics) do not appear to be effective in treating unipolar depression and may, thus, simply burden people suffering from unipolar depression with side effects.

■ What Is Major Depression?

Major depression is a mood state that goes well beyond temporarily feeling sad or blue. It is a serious medical illness that affects one’s thoughts, feelings, behavior, mood, and physical health.

Major depression can occur at any age, even in rare cases starting as young as preschool. Some individuals may only have one episode of depression in a lifetime, but more often people have recurrent episodes. More than half of those who experience a first episode of depression will have at least one other episode in their lives. Some people may have several episodes in the course of a year, and others may have ongoing symptoms. If untreated, episodes commonly last anywhere from a few months to many years.

The outward behavior of the person with depression often does not attract attention. The behavior of the depressed individual, although quite worrisome to family members and friends and even to him- or herself, rarely disrupts the lives of others to the extent that some other serious mental illnesses do.

However, major depression is disruptive in other ways, by causing people to withdraw from their relationships, from their work, and from the very fabric of society. In fact, major depression ranks as the largest cause of disability in the developed world, and the fourth-largest cause of disability in the developing world. To make matters worse, researchers believe that more than half of people who succeed in committing suicide were suffering from depression at the time.

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The normal human emotion we sometimes call “depression” is a common response to a loss, failure, or disappointment. Major depression is different. It is a serious emotional and biological disease, which—with a correct diagnosis—can typically be treated effectively. Major depression may require long-term treatment to keep symptoms from returning, just like any other chronic medical illness. For some, biological depression is a life-long condition in which periods of wellness alternate with recurrences of illness.

The use of alcohol, a central nervous system depressant, can be a serious complication for depressed individuals who use it to try to change how they feel. All alcohol should be avoided during treatment for depression for several reasons. First, after its initial anti-anxiety effect, alcohol produces increased feelings of depression. Regular alcohol alone can cause a depressed mood that lasts for weeks, even after the use of alcohol stops. Second, in combination with many antidepressants, alcohol can make drug side effects much worse, even dangerously so, and may make antidepressants less effective. Third, alcohol reduces inhibitions, which increases the risk of suicide or suicidal gestures.

Getting an accurate diagnosis is important. First, rule out other possible medical conditions that mimic depression—such as hypothyroidism (too little thyroid), substance abuse, infectious processes, anemia, and neurological disorders.

■ What Are the Symptoms?

The onset of the first episode of major depression may not be obvious, if it is brief or mild. Unrecognized or left untreated, however, it may recur with greater seriousness or progress to a syndrome with the following symptoms: a profoundly sad or irritable mood lasting at least two weeks, and accompanied by pronounced changes in sleep, appetite, energy, ability to concentrate and remember, a lack of interest in usual activities, and a decreased ability to experience pleasure. Frequently, there

are feelings of hopelessness, worthlessness, sadness, emptiness, or guilt. Very depressed persons cannot respond to positive events in their lives. A depressive episode may develop gradually or affect a person quite suddenly, and it frequently is unrelated to current events in the person's life.

The symptoms of clinical depression characteristically represent a significant change in how a person functions. Often, when all of those symptoms co-exist at a severe level for a long time, individuals become so discouraged and hopeless that death seems preferable to life. These feelings can lead to passive suicidal wishes, suicidal plans, and even attempted and completed suicide.

Changes in sleep: The changes in sleep can go in either direction. Some depressed individuals have difficulty falling asleep, wake throughout the night, and awaken an hour to several hours earlier than desired in the morning. Other individuals experiencing depression will sleep more than the usual amount. In most cases, individuals awaken without feeling rested.

Changes in appetite: Many people in a clinical depression experience a decrease in appetite and weight loss that can often be considerable. Others will experience an increased desire to eat and will gain weight. Most of these people will report that the food they are eating does not actually appeal to them.

Impaired concentration and decision making: The inability to concentrate and make decisions experienced by depressed individuals can be a frightening aspect of the disorder. In the midst of a severe depression, individuals may find that they cannot follow the thread of a simple newspaper article or the story line of a half-hour comedy on television. Major decision making is often impossible. This often leads depressed individuals to feel as though they are literally losing their minds.

Loss of energy: Equally distressing to depressed persons is the loss of energy and profound fatigue experienced by both those who sleep more and those who sleep less during an episode. Mental speed and activity are usually reduced, as is the ability to perform normal daily routines. Ideas are fewer, and responses to the environment are painfully slowed.

Loss of interest: Depressed people feel sad and lose interest in their usual activities. They lose their capacity to experience pleasure. For instance, eating and sex are often no longer enjoyable. Former regular activities seem boring or unrewarding, and the ability to feel and offer love may be diminished or lost.

Low self-esteem: During periods of depression, individuals often dwell on memories of losses or failures, and they feel excessive guilt and helplessness. Negative thoughts, such as “I am not worth much” or “the world is a terrible place,” may take over.

Feelings of hopelessness or guilt: The symptoms of depression often come together to produce a strong feeling of hopelessness, a belief that nothing will ever improve. Periods of depression can lead to the wish to die or thoughts of killing oneself.

Movement changes: People who are depressed may literally look slowed down—physically depleted—or alternatively, activated and agitated. For example, a depressed person may awaken very early in the morning and pace the floor for hours.

Depression may be as disabling, in terms of time spent in bed and loss of work productivity, as other chronic illnesses, like hypertension and diabetes. It has been estimated that the annual cost of depressive illness in the United States is \$80 billion, due to lost productivity and to illness care.

Who Develops Major Depression?

All age groups and all racial, ethnic, and socioeconomic groups suffer from depression. An estimated 15 million American adults are affected by major depression in a given year. Only about one-third of those with major depression receive some form of treatment.

Youth: Many symptoms of depression in children and adolescents are similar to those in other age groups, but there are some differences. Grade school children are more likely to complain of aches and pains than they are to report feeling hopeless or sad. Depressed teens may “act out” by showing anger or irritability, becoming aggressive, abusing drugs or alcohol, doing poorly in school, or running away. In contrast to outward appearances when acting out, an adolescent’s own experience of depression is of feeling isolated, empty, and hopeless. Since the 1960s, the rate of suicides among children and adolescents has dramatically increased, but thankfully the rate has begun to decrease again in the past few years. Even with the recent decrease, suicide is still the third-leading cause of death among children ages 15 to 19, following accidents and homicides. Therefore, it is essential for young people with severe symptoms or symptoms lasting for several weeks to be evaluated by doctors. Even though the use of antidepressant medication in children may sometimes be controversial, some observe that depression is itself lethal for many, and lack of treatment is also a serious concern.

Adults age 65 and over: An estimated 10 percent of American adults age 65 and older have a diagnosable depressive disorder, including major depression, dysthymia (a mild form of depression), and adjustment disorder with depressed mood. Experts believe that depression is under-treated in older adults because it can be difficult to recognize. Certain problems associated with aging, such as backaches, headaches, joint pain, or stomach problems, are often not recognized as signs of depression. Medical illnesses common in the elderly, such as Parkinson's disease, dementia, and heart disease, often bring with them symptoms that overlap with those of a depression syndrome, and physicians and families may not recognize the concurrent presence of major depression. Contrary to popular belief, depression is not a normal part of aging. It can be successfully treated when recognized and diagnosed by a physician. Treatment is especially important in this population, due to a higher risk of associated suicide (80 percent of suicide completions in the elderly had major depression, compared to 30 percent of younger victims).

What Causes Major Depression?

The general scientific understanding is that depression does not have a single cause; it arises from multiple factors that may need to occur simultaneously. A person's life experience, genetic inheritance, age, sex, brain chemistry imbalance, hormone changes, substance use, and other illnesses all play significant roles in the development of a depression. It also may occur that there is no observable trigger leading to the illness; depression may occur spontaneously and be unassociated with any life crisis, physical illness, or other currently known risks.

Mood disorders and suicides tend to run in families. In the case of complete biologic inheritance, such as with identical twins, it appears that only about 30 percent of the time when one twin develops depression will the other twin ever do so as well. We know that a biologically inherited tendency to develop depression is associated with a younger age of depression onset, and that new onset depression occurring after age 60 is less likely to be due to a genetic predisposition. Life factors and events seem to influence whether an inherited, biologic (genetic) tendency to develop depression will ever lead to an episode of major depression.

Social variables like marital status, financial standing, and place of residence have some relationship to the likelihood of developing depression, but conclusions are not easily reached



as to which causes the other. For instance, though depression is more common in people who are homeless, it may be that the depression strongly influences why any given person becomes homeless. We also know that long-lasting stressors like unemployment or a difficult marriage play a more significant role in developing depression than sudden stressors like an argument or receiving bad news.

Traumatic experiences may not only contribute to one's general state of stress, but also seem to alter how the brain functions for years to come. Early-life traumatic experiences have been shown to cause long-term changes in how the brain responds to future fears and stresses. It is felt that this may be what accounts for the greater lifetime incidence of major depression in people who have a history of significant childhood trauma.

Other proposed biologic pathways in the development of depression include changes observed in regional brain functioning. For instance, imaging studies have shown consistently that the left, front portion of the brain becomes less active during depression. Also, brain patterns during sleep change in a characteristic way during depression. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.

Other factors that have been linked to depression include abnormalities in neurotransmitter levels or function (particularly of serotonin, norepinephrine, and dopamine), a history of sleep disturbances, medical illness, chronic pain, anxiety, attention-deficit hyperactivity disorder, alcoholism, or drug abuse. Our current understanding is that major depression can have many causes and can develop from a variety of biologic pathways.

■ How Is Major Depression Treated?

Of all the mental illnesses, major depression is among the most responsive to treatment. Although major depression can be a devastating illness, it is highly treatable. Most people suffering from serious depression can be effectively treated and can return to their routine daily activities and experience relief from their feelings of depression. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of the illness. There are three well-established types of treatment for depression: medications, psychotherapy, and electroconvulsive therapy (ECT). For some people who have a seasonal component to their depression, light therapy may be useful. These treatments may be used alone or in combination.

Medications

It often takes two to four weeks for antidepressants to start having an effect, and six to 12 weeks for antidepressants to have their full effect. In some cases, patients may have to try various doses and different antidepressants before finding the one or the combination that is most effective. Friends and relatives will usually notice an improvement on medication before the depressed person him- or herself will notice any changes. Antidepressant medications are not habit-forming. Below is a list of some of the options:

- Selective serotonin reuptake inhibitors (SSRIs) act specifically on the neurotransmitter serotonin. They are the most common agents prescribed for depression worldwide. These agents block the reuptake of serotonin from the synapse to the nerve, thus artificially increasing the serotonin that is available in the synapse (this is functional serotonin, since it can become involved in signal transmission, the cardinal function of neurotransmitters). SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), and fluvoxamine (Luvox).
- Serotonin and norepinephrine reuptake inhibitors (SNRIs) are the second-most popular antidepressants worldwide. These agents block the reuptake of both serotonin and norepinephrine from the synapse into the nerve (thus increasing the amounts of these chemicals that can participate in signal transmission). SNRIs include venlafaxine (Effexor) and duloxetine (Cymbalta).
- Bupropion (Wellbutrin) is a very popular antidepressant medication classified as a norepinephrine-dopamine

reuptake inhibitor (NDRI). It acts by blocking the reuptake of dopamine and norepinephrine.

- Mirtazapine (Remeron) works differently from the compounds discussed above. Mirtazapine targets specific serotonin and norepinephrine receptors in the brain, thus indirectly increasing the activity of several brain circuits.
- Tricyclic antidepressants (TCAs) are older agents seldom used now as first-line treatment. They work similarly to the SNRIs, but have other neurochemical properties which result in very high rates of side effects, as compared to almost all other antidepressants. They are sometimes used in cases where other antidepressants have not worked. TCAs include amitriptyline (Elavil, Limbitrol), desipramine (Norpramin), doxepin (Sinequan), imipramine (Norpramin, Tofranil), nortriptyline (Pamelor, Aventyl), and protriptyline (Vivactil).
- Monoamine oxidase inhibitors (MAOIs) are also seldom used now. They work by inactivating enzymes in the brain which catabolize (chew up) serotonin, norepinephrine, and dopamine from the synapse, thus increasing the levels of these chemicals in the brain. They can sometimes be effective for people who do not respond to other medications or who have “atypical” depression with marked anxiety, excessive sleeping, irritability, hypochondria, or phobic characteristics. However, they are the least safe antidepressants to use, as they have important medication interactions and require adherence to a particular diet. MAOIs include phenelzine (Nardil), isocarboxazid (Marplan), and tranylcypromine sulfate (Parnate).



■ Non-antidepressant adjunctive agents: Often, psychiatrists will combine the antidepressants mentioned above with each other (we call this a “combination”) or with agents which are not antidepressants themselves (we call this “augmentation”). These latter agents can include the atypical antipsychotic agents [aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), risperidone (Risperdal)], bupirone (Buspar), thyroid hormone (triiodothyronine, or “T3”), the stimulants [methylphenidate (Ritalin), dextroamphetamine (Adderall)], dopamine receptor agonists [pramipexole (Mirapex), ropinirole (Requip)], lithium, lamotrigine (Lamictal), s-adenosyl-methionine (SAME), pindolol, and steroid hormones (testosterone, estrogen, DHEA).


Of note: Although antidepressants generally reduce suicidal thoughts, along with other symptoms of depression, in the vast majority of children who benefit from them, children starting an antidepressant medication should be monitored frequently for the emergence or worsening of suicidal thoughts due to the association, in some studies, of increased suicidality in a small minority of patients on antidepressant medication. (The FDA Public Health Advisory on this issue is available at: www.fda.gov/cder/drug/antidepressants/SSRIPHA200410.htm.)

Medications often effectively control the symptoms of depression, but people with this disorder must learn to recognize their individual patterns of illness and learn ways to cope with them. Taking medication prescribed by a doctor is just one way to manage major depression. Psychotherapy is another way to help manage depression, and research demonstrates that a combination of medication and psychotherapy is often the most effective treatment. Education, peer, and mutual support endeavors are also useful in supporting recovery.

Psychotherapy

There are several types of psychotherapy that have been shown to be effective for depression, including cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). In general, these two types of therapies are short-term; treatments usually last only 10 to 20 weeks. Research has shown that mild to moderate depression can often be treated successfully with either medication or psychotherapy alone. However, severe depression appears more likely to respond to a combination of these two treatments.

■ Cognitive-behavioral therapy (CBT) helps to change the negative thinking and behavior associated with depression while teaching people how to unlearn the behavioral patterns that contribute to their illness. The goal of this therapy is to



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recognize negative thoughts or mindsets (e.g., “I can’t do anything right”) and replace them with positive thoughts (e.g., “I can do this correctly”), which leads to more effective, beneficial behavior. It is also noted that simply changing one’s behavior can lead to an improvement in thoughts and mood. This might be as simple as leaving the house and taking a 15-minute walk every day.

- Interpersonal therapy (IPT) focuses on improving personal relationships that may contribute to a person’s depression. The therapist teaches people to evaluate their interactions with others and to become aware of self-isolation and difficulties getting along with, relating to, or understanding others.
- Psychodynamic psychotherapy is often more available than CBT and IPT in many communities, but researchers in depression recommend it less often, due to a relative lack of data indicating that it works for this condition. This type of therapy is based on discovering one’s unconscious desires and greater self-awareness.

Other forms of psychosocial treatments may help people and their families manage major depression more effectively. These treatments include psychoeducation, family psychoeducation, and self-help and support groups.

- Psychoeducation involves teaching a person about his or her illness, how to treat it, and how to recognize signs of relapse so that he or she can get necessary treatment before the illness worsens or occurs again.
- Family psychoeducation helps to reduce distress, confusion, and anxieties within the family, which may help the person recover.
- Self-help and support groups for people and families dealing with mental illnesses are becoming more widely available. In this venue, people rely on their lived experience to share frustrations and successes, referrals to qualified specialists and community resources, and information about what works best when trying to recover. They also share friendship and hope for themselves, their loved ones, and others in the group.

Electroconvulsive therapy (ECT)

ECT is a highly effective treatment for severe depression episodes. When medication, psychotherapy, or a combination of the two is not effective, or if treatments are too slow to relieve severe symptoms such as psychosis or thoughts of suicide, or if a person cannot take antidepressants, ECT may be considered.

■ How Successful Are Treatments for a Person with Major Depression?

How well treatment works depends on the type of depression, its severity, how long it has been going on, and the medical and psychological interventions offered. A new multicenter trial funded by the National Institute of Mental Health (NIMH) called *STAR*D* is currently offering new information on treatment outcomes in real-world settings. This is a study to watch, going forward, and is referenced in the *Resources* section at the end of this brochure.

The development over the past 25 years of antidepressants and mood-stabilizing drugs has revolutionized the treatment of clinical depression, particularly for those with more serious or recurrent forms of the disorder. Biological treatments are effective overall, and most people with biological depression get significant relief from medications—whether the depression is mild or severe, recent or long-term. Left untreated, however, depression can become more serious or go on indefinitely. Treatment is important because it works, and continued treatment after getting well can prevent recurrences. More than half of those who experience a first episode of depression will have at least one other episode in their lives. After two episodes, the chances of having a third episode are even greater.

The *STAR*D* study noted above has already shown that it can take up to six to eight weeks to get a good response to treatment, and that people should keep trying different strategies. For instance, one-third of people who did not get better with a first treatment got all symptoms reduced (into remission) with the addition of a second medicine. Another one-quarter improved to remission after switching to another antidepressant. This study helps to support the idea that staying with the battle against depression is essential.

Although most people who live with depression can be treated successfully as outpatients, severe episodes and episodes accompanied by suicidal thinking may require

brief hospitalization for careful evaluation, protection, and initiation of treatment. In combined treatments, medications are used to treat the symptoms of depression, while psychotherapy is used to help alleviate the problems depression causes in daily living. Psychotherapy is particularly important to undertake for anyone experiencing suicidal thoughts or profound psychosocial impairment.

■ **What Are the Possible Side Effects of Drugs Used to Treat Major Depression?**

Different medications produce different side effects, and people differ in the type and severity of side effects they experience. About 50 percent of people who take antidepressant medications experience some side effects, particularly during the first weeks of treatment. Side effects that are particularly bothersome can often be treated by changing the dose of the medication, switching to a different medication, or treating the side effects directly with additional medications. Rarely, serious side effects such as fainting, heart problems, or seizure may occur, but they are almost always treatable.

■ SSRIs and SNRIs, the most commonly prescribed treatments for depression, have similar side effect profiles. Common side effects with SSRIs and SNRIs include nausea, dry mouth, headaches, nervousness, insomnia, daytime sleepiness, diarrhea, constipation, rash, agitation, mild to modest weight gain, or sexual side effects, such as problems with arousal or satisfaction. SSRIs and SNRIs should never be combined with MAOIs; combination of the two can result in serious health problems and may even be fatal. Effexor and Cymbalta should be used with some caution in those with high blood pressure or cardiovascular disorder. Effexor and Cymbalta are generally not recommended for young children.

■ Bupropion (Wellbutrin) generally causes fewer side effects than most other antidepressants (particularly nausea, sexual side effects, weight gain, and fatigue or sleepiness). Its side effects include restlessness, insomnia, headache or a worsening of pre-existing migraine tendencies, tremor, dry mouth, agitation, rapid heartbeat, dizziness, nausea, constipation, menstrual complaints, and rash. For some people, Wellbutrin causes significant anxiety symptoms, and for others it is a very effective treatment for anxiety. However, Wellbutrin has been shown to increase the likelihood of having a seizure in those prone to this

occurrence at doses above 450mg per day, and should never be taken at doses above the recommended maximum of 450mg per day. Wellbutrin is contra-indicated in patients with a history of an eating disorder, head injury, or seizure disorder.

- Mirtazapine (Remeron) is used less often than other, newer antidepressants (SSRIs, SNRIs, bupropion), because it is associated with more weight gain and sedation and sleepiness. However, it appears to be less likely to result in insomnia, sexual side effects, and nausea than the SSRIs and SNRIs. Other side effects include headaches, dry mouth, and constipation. Remeron is not recommended for those with hepatic or renal dysfunction, a history of mania, or seizure disorder.

- Tricyclic antidepressants (TCAs) generally have more side effects than all other antidepressants, including headaches, sleepiness and drowsiness, significant weight gain, nervousness, dry mouth, constipation, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, skin rash, heart conduction changes, and weight gain.

- Monoamine oxidase inhibitors (MAOIs) are also seldom used. While their side effect profile is not as burdensome as the TCAs', the MAOIs are generally less safe than other antidepressants. People taking MAOIs may have to be careful about eating certain fermented foods like alcohol or cheese, as they contain high amounts of tyramine, which can cause severe high blood pressure in combination with a MAOI. Other, less serious side effects may also occur with MAOIs, including weight gain, constipation, dry mouth, dizziness, headache, drowsiness, insomnia, and sexual side effects, such as problems with arousal or satisfaction. MAOIs should generally not be combined with other antidepressant medications, and due to multiple other medication interactions, every treating physician should be notified that a consumer is taking this medication.

Specific body chemistry, age, the type and dosage of medication taken, other medications being taken (including non-prescription medications and supplements), and other medical conditions can all contribute to the side effects an individual may experience. Therefore, it is important always to discuss medications, medical conditions, and side effects with your health care provider.



■ What Type of Help Does a Person with Major Depression Need?

Above all, people with major depression need accurate diagnosis and early treatment. Family, friends, and coworkers should encourage a depressed person to seek expert evaluation. Those who are ill also need understanding, compassion, patience, and respect.

Insurance plans often make primary care physicians a required entry point for a consumer to receive psychiatric treatment, and different primary care physicians vary in their comfort levels with managing major depression. Some primary care physicians will feel comfortable initiating medications, for instance, while others prefer always to refer to a specialist. Consumers and families should not feel afraid to seek expert advice early in the course of a depressive illness if they feel things are not improving. It is recognized that the longer a person remains depressed, the harder successful treatment becomes. It is important that every depressed patient be thoroughly examined for possible physical illnesses, as there are some occasions when depression is being caused by another medical problem.

Experts in the treatment of depression include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, some mental health counselors, and consumers and families themselves. A *psychiatrist* is a medical doctor who specializes in mental disorders and in most states is the only one of the mental health professionals who can prescribe medication. A *clinical psychologist* conducts psychotherapy and works with individuals, couples, and families to resolve problems associated with depression. *Psychiatric or clinical social workers* are trained in counseling, psychotherapy, and client-centered advocacy, including information, referral, and direct

intervention with government and civic agencies. *Mental health counselors* provide professional counseling services that may include psychotherapy, and they have a professional goal of promoting healthy, satisfying lifestyles. Peer education and support can promote recovery. Attention to lifestyle, including diet, exercise, and smoking cessation, can result in better health, including mental health.

■ How Can Family and Friends Help?

Talking through feelings may help the depressed person recognize that he or she needs professional help, so friends and family should be willing to listen. They should be willing to find out more about depression, to learn the symptoms, and to help with the treatment.

People living with depression often must be encouraged to seek help. If they are severely depressed, they may need help finding a health care professional, and may depend on being brought in by someone else for their diagnosis and treatment. Once treatment has begun, they may need help managing their medications, recognizing side effects, and observing changes in symptoms. Do not ignore remarks about suicide or death. Report them to the health care provider.

If a person does not want his or her health care professional to speak with family or friends about the details of an illness, the health care professional is bound to honor the person's wishes, except in case of emergency. However, friends and family members are not restricted from offering information to the health care professional by telephone or in writing. This is particularly important to do when there is concern for the safety of the person living with depression, such as threats to commit suicide.

Friends and family members who understand major depression are in the best position to help the person living with depression. They understand that the illness affects functioning, personality, attitude, and perspective, as well as what to expect during acute stages of depression and over the long term. They also understand that their own lives will be disrupted as well.

Because depression often means a loss of self-esteem or self-confidence, friends and family should try to increase the person's feeling of self-worth by maintaining as normal

a relationship as possible, talking through unwarranted negative thinking (such as examining the evidence against the idea of being worthless), encouraging efforts to improve, and acknowledging that the person is suffering from an illness. Care and respect are important ways to help someone who is having difficulty at work, home, or school. Pointing out the effectiveness of treatments may be useful when feelings of hopelessness become intense. In doing all of this, however, it is important to acknowledge that the depressed person's lack of confidence or feelings of hopelessness seem reasonable to him or her at the time, and that things will look different when the illness begins to improve.

—Written by Ken Duckworth, M.D.
with thanks to George Papakostas, M.D.



■ What Is NAMI?

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends, and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

To learn more about your local affiliate:

Call your state's NAMI office

Write to: NAMI • 2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042

Contact the NAMI Information Helpline at

1 (800) 950-NAMI (6264) or

Visit NAMI's Web site at www.nami.org

Many NAMI affiliates offer programs designed to assist individuals and families affected by mental illness:

NAMI Peer-to-Peer is a free 9-week education course on the topic of recovery for any person with a serious mental illness. Led by mentors who themselves have achieved recovery from mental illness, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills, and self-care.

NAMI Family-to-Family is a free 12-week course for family caregivers of adults with mental illness. Taught by trained NAMI family members who have relatives with mental illness, the course provides caregivers with communication and problem-solving techniques, coping mechanisms, and the self-care skills needed to deal with their loved ones and the impact on the family.

NAMI In Our Own Voice is a public education presentation. It enriches the audiences' understanding of how the over 58 million Americans contending with mental illness cope while also reclaiming rich and meaningful lives. Presented by two trained speakers who themselves live with mental illness, the presentation includes a brief video and personal testimonials, lasts 60-90 minutes, and is offered to a variety of audiences free of charge.

NAMI Connection is a recovery support group for adults with mental illness regardless of their diagnosis. Every group is offered free of charge and meets weekly for 90 minutes. NAMI Connection offers a casual and relaxed approach to

sharing the challenges and successes of coping with mental illness. The groups are led by trained individuals who are in recovery--people who understand the challenges others with mental illness face.

NAMI Basics is a free educational program for parents and other primary caregivers of children and adolescents with mental illness. The course is presented in 6 different classes, provides learning and practical insights for families, and is taught by trained parents and caregivers who have lived similar experiences with their own children.

■ Information Resources:

www.nami.org NAMI's Web site is visited by over half a million unique visitors each month and features the latest information on mental illness, medication and treatment, news, and resources promoting support, education, and advocacy. Special Web sections include resources for Veterans, college students, multicultural groups, and others. Additional features include online discussion groups and options for registration through **myNAMI**, which enables users to receive personalized information and e-mail updates on a variety of topics of their choosing.

1 (800) 950-NAMI, the NAMI Information HelpLine receives over 4,000 requests each month from individuals needing support, referral, and information. Over 60 fact sheets on a variety of topics are available along with referrals to NAMI's network of local affiliates in communities across the country.

Peer-to-Peer: www.nami.org/peertopeer

Family-to-Family: www.nami.org/familytofamily

In Our Own Voice: www.nami.org/IOOV

Connection: www.nami.org/connection

Basics: www.nami.org/basics

Star Center: www.consumerstar.org

The STAR Center provides Support, Technical Assistance, and Resources to assist consumer-operated and consumer-helper programs in meeting the needs of under-served populations. In pursuit of this mission, it offers leadership training, national teleconferences, listening sessions, forums, scholarships for consumers and consumer-operated organizations, as well as online resources.

National Institute of Mental Health (NIMH):

www.nimh.nih.gov

■ Books About Major Depression

The following books are a good place to start learning about depression. They are available in libraries or can be ordered from booksellers, including a link to *Amazon.com* at www.nami.org/store. New books are also listed in the *Advocate*, the NAMI news magazine available to NAMI members.

100 Questions & Answers About Depression (2007) by Ava T. Albrecht, M.D. and Charles Herrick, M.D.

Against Depression (2005), by Peter D. Kramer

Darkness Visible: A Memoir of Madness (1990)
by William Styron

Get It Done When You're Depressed: 50 Strategies for Keeping Your Life on Track (2008) by Julie A. Fast and John D. Preston, Psy.D., A.B.P.P.

Lincoln's Melancholy (2005) by Joshua Wolf Shenk

More than Moody: Recognizing and Treating Adolescent Depression (2003) by Harold S. Koplewicz, M.D.

The Noonday Demon (2001) by Andrew Solomon

Overcoming Depression, 3rd ed. (1997) by Demetri Papolos, M.D., and Janice Papolos

The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression (2003) by Belisa Lozano-Vranich, Psy.D., and Jorge R. Petit, M.D.

Standing In the Shadows: Understanding and Overcoming Depression in Black Men (2004) by John Head

What To Do When Someone You Love Is Depressed (1998)
by Mitch Golant, Ph.D., and Susan K Golant

When Nothing Matters Anymore: A Survival Guide for Depressed Teens (2007) by Bev Cobain, R.N.C.

NAMI Publications

NAMI has several fact sheets related to depression, including *Depression in Older Persons*, *Seasonal Affective Disorder*, *Suicide*, and *Women and Depression*, as well as a fact sheet on specific medications used to treat depression. NAMI also offers a brochure on *Women and Depression*. These materials are also available by calling the NAMI Information Helpline at 1 (800) 950-NAMI (6264). This and other information can be found by visiting our Web site, www.nami.org.





National Alliance on Mental Illness

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