

# depression



National Alliance on Mental Illness

*Find help. Find hope.*



National Alliance on Mental Illness

*Find help. Find hope.*

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

Written by NAMI Medical Director Ken Duckworth, M.D. with additional input from Richard Shelton, M.D. of Vanderbilt University.

Copyright 2012 NAMI, the National Alliance on Mental Illness.  
Copies of this publication can be purchased at [www.nami.org/store](http://www.nami.org/store).

NAMI, 3803 N. Fairfax Dr., Suite 100, Arlington VA 22203  
[www.nami.org](http://www.nami.org)

HelpLine: (800) 950-NAMI (6264)

Twitter: NAMICommunicate

Facebook: [www.facebook.com/officialNAMI](http://www.facebook.com/officialNAMI)

*Stock photos used in this publication are not meant to indicate any particular attitude or opinion on the part of those whose images are being used and are not intended to indicate an endorsement by the subjects.*

Each year depression affects 5-8 percent of adults in the United States. This means that approximately 25 million Americans will have an episode of major depression this year alone. Depression occurs 70 percent more frequently in women than in men for reasons that are not fully understood. Without treatment, the frequency and the severity of symptoms tend to increase over time.

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

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, insomnia, fatigue, appetite disturbances, excessive guilt and thoughts of suicide. Left untreated, depression can lead to serious impairment in daily functioning and even suicide, which is the 10th leading cause of death in the U.S. Researchers believe that more than one-half of people who die by suicide are experiencing depression. Depression is a leading cause of disability worldwide and represents a global public health challenge; according to the World Health Organization it's the fourth-leading contributor to Global Burden of Disease and by 2020, depression is projected to be the the second-leading cause. Devastating as this disease may be, it is treatable in most people. 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.

## Major Depression Defined

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. Major depression may require long-term treatment to keep symptoms from returning just like any other chronic medical illness.

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. Depression is a life-long condition in which periods of wellness alternate with recurrences of illness.

Depression can occur at any age, in rare cases starting in children in preschool. Some individuals may only have one episode of depression in a lifetime, but often people have recurrent episodes. More than one-half of people who experience a first episode of depression will have at least one other episode during his/her lifetime. 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 use of alcohol, a central nervous system depressant, can be a serious complication for depressed individuals who use it to try to change moods. Alcohol should generally be avoided during treatment for depression for several reasons. First, after its initial anti-anxiety effect, alcohol can cause increased feelings of anxiety or depression. Alcohol 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.

Getting an accurate diagnosis is important. First, rule out other possible medical conditions that mimic depression, such as hypothyroidism (underactive thyroid), complications from substance abuse or dependence, infectious diseases, anemia and certain neurological disorders. Understanding the psychiatric context—including the risk of bipolar disorder and the assessment of safety risk—is also an essential aspect of an evaluation.

## Symptoms and Diagnosis

Depression can be difficult to detect from the outside looking in, but for those who experience major depression, it is disruptive in a multitude of ways, including withdrawal from relationships.

The symptoms of clinical depression usually represent a significant change in how a person functions. Sometimes, individuals become so discouraged and hopeless that death seems preferable to life. These feelings can lead to suicidal ideation, attempts and death by suicide. The following are key areas where depression causes major changes in people.

**Changes in sleep.** Some people experience difficulty in falling asleep, wake throughout the night and awaken an hour to

several hours earlier than desired in the morning. Other people experiencing depression will sleep excessively—for much longer than they used to.

**Changes in appetite.** Many people in the midst of depression experience a decrease in appetite and, sometimes, noticeable weight loss. Some people eat more, sometimes resulting in weight gain.

**Poor concentration.** The inability to concentrate and/or make decisions is a scary aspect of depression. During a severe depression, many people cannot follow the thread of a simple newspaper article or the plot of a 30-minute TV show. Major decision-making is often impossible. This leads depressed individuals to feel as though they are literally losing their minds.

**Loss of energy.** The loss of energy and profound fatigue often affects people living with depression. Mental speed and activity are usually reduced, as is the ability to perform normal daily routines. If you're living with depression, you will likely find that you come up with responses to your environment much more slowly.



**Lack of interest.** During depression, people feel sad and lose interest in usual activities. You might even lose the capacity to experience pleasure. For instance, eating and sex are often no longer appealing. Formerly enjoyable 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, people dwell on memories of losses or failures and feel excessive guilt and helplessness. “I am a loser” or “the world is a terrible place” may take over and increase the risk of suicide.

**Hopelessness or guilt.** The symptoms of depression often come together to produce a strong feeling of hopelessness, or a belief that nothing will ever improve. These feelings can lead to thoughts of suicide.

**Movement changes.** People who are depressed may literally look “slowed down” and 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.

## Diagnosis

The *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* is the current reference used by health care professionals to diagnose mental illnesses such as depression. This manual was first published in 1952 and has since gone through several revisions. The current edition was published in 1994 (The *DSM-IV-TR*, or text revision, was produced in 2000) and lists over 200 mental health conditions and the criteria required for each one in making an appropriate diagnosis. The *DSM-5* is scheduled to publish in 2013.

In the *DSM-IV*, depression is classified as a mood disorder. The *DSM-IV's* criteria for a major depressive episode (which needs to last longer than two weeks) include:

- Depressed mood (such as feelings of sadness or emptiness)
- Reduced interest in activities that used to be enjoyed
- Change in appetite or weight (up or down)
- Sleep disturbances (either not being able to sleep well or sleeping too much)
- Feeling agitated or slowed down
- Fatigue or loss of energy
- Feeling worthless or excessive guilt
- Difficulty think, concentrate, or troubles making decisions about thing
- Suicidal thoughts or intentions

Diagnostic criteria for depression can fall into categories: Affective, or mood, symptoms; behavioral symptoms including withdrawal; cognitive symptoms including problems concentrating or making decisions; and somatic or physical symptoms that may include sleep disturbances.

There is a strong possibility that a depressive episode can be a part of bipolar disorder. Having a physician make the right distinction between unipolar depression and bipolar depression is critical because treatments for these two depressive disorders differ. The use of antidepressants, (the cornerstone of treatment of major depression) can sometimes activate manic symptoms or even worsen depressive symptoms, including suicidal thinking, in people with bipolar depression. At the same time, antidepressants do not appear to be particularly effective for treating bipolar depression. In major depression associated with bipolar disorder, mood stabilizers and psychosocial treatments—not antidepressants—have a strong evidence base and can often be effective. Speaking with a mental health care provider can help guide this process.

### **Tanya's Story**

On the night of June 12, 1994, my sister Nicole Brown Simpson was murdered. My pain was indescribable and insurmountable. Because of the notoriety of the incident, it was difficult for me to go through the normal grieving process. I suppressed my emotions and remained quiet.

Over the next 10 years, my life was fairly steady. I had a stable job and was financially secure. Then, in 2004, I was engaged to be married. Four days before the wedding, my then-fiancé canceled. I was so clinically depressed that it was impossible to even get out of bed. I felt spiritually, mentally and physically paralyzed. Little did I know that this would be the catalyst toward a new life.

For one month I was self-destructive. I drank alcohol, took pills and was horribly angry. I was in a negative and unhealthy space and I had no idea what to do. Then, on Oct. 9, 2004, all of the emotions that I had suppressed for 10 years exploded. During a family gathering, I verbally lashed out at my loved ones and devastated some of the most important people in my life.

I found myself alone in my bedroom holding pills in my hand. I wanted the pain to end. However, there was a part of me that

realized I was here for a greater good. I didn't want to die. At that very moment my sister entered the room. I dropped the pills and told her to get me away from here. She took me to a friend's house where I could rest and sober up. The next morning she called and asked, "Are you ready?" I knew exactly what she meant. I was ready to take the next step toward healing.

Within a few hours I was in professional care. This particular in-patient program saved my life. I learned valuable tools necessary to regain life skills and coping strategies to live a productive life.

Journaling was one of these coping skills and it became my lifeline. I would journal my thoughts and feelings every day. I needed to purge all of the emotions locked inside for the last 10 years. After 10 days of being an in-patient student, I graduated to out-patient care. This is where I was able to fine-tune the skills I learned and apply them to the real world.

The out-patient program was my survival kit for the next two months. Step-by-step, I came closer to my goal of returning to a normal life by setting small goals for myself. Recovery was a process, and each accomplishment provided me joy.

By the end of the program I was well on my way to being the best I can possibly be.

I am human. I relapse on some days. I reached out to NAMI Orange County (Calif.) and attended the NAMI Peer-to-Peer program there as a stepping stone into the outside world. I now have the tools, skills and strategies to help me get through the ups and downs of life. I have an inner strength that can get me through anything!

## Who's at Risk?

All age groups and all racial, ethnic and socioeconomic groups can experience depression. An estimated 25 million American adults are affected by major depression in a given year, but only one-half ever receive treatment.

### **Children, Teens and Young Adults**

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. Suicide is the third-leading cause of death among children aged 15-19, 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 Aged 65+**

An estimated 10 percent of American adults age 65 and older have a diagnosable depressive disorder. 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 have 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.

### **Women and Minorities**

Non-white individuals often face more barriers to appropriate mental health care services, including language and cultural, distrust of mainstream medicine, lack of health insurance and stigma surrounding depression and mental health disorders. It is crucial to find a mental health care provider who can address cultural needs and values.

Middle-aged Hispanic women have the highest rates of depression (43 percent), followed by middle-aged African American women (27 percent), white women (22 percent), and Asian-American women (14 percent) according to a nationwide study of women’s health published in the August 2004 *American Journal of Public Health*.

Other risk factors are: racial/ethnic discrimination, poverty, segregation into low-status and high-stress jobs, unemployment, poor health, larger family sizes, marital dissolution and single parenthood. Strong feelings of stigma as part of ethnic family cultures also play a role. Women who immigrate to the United States and face adjusting to a new culture are more likely to have major depression.

Young Asian-American women have the highest depression rates of any group and the second highest rate of suicide among 15- to 24-year-old females. American Indian/Alaska Native adolescent boys are the most likely to die from suicide.

### ***Reproductive Events***

A woman's menstrual cycle, post-pregnancy period and infertility problems can trigger mood fluctuations and depression. Research has confirmed that hormones have an effect on the brain chemistry that controls emotions and mood.

Many women experience behavioral and physical changes during their menstrual cycle. These can be severe, occur regularly, and include depressed feelings, irritability, and other emotional and physical changes. With premenstrual syndrome (PMS) or premenstrual dysphoric disorder (PMDD), the changes typically start after the ovaries produce and discharge eggs and the changes become gradually worse until menstruation starts. Researchers are exploring how the cyclical rise and fall of hormones, including estrogen, may affect the brain chemistry associated with depressive illness.

Post-pregnancy or post-partum changes can vary from temporary "blues" right after childbirth, to an episode of major depression, to severe, incapacitating depression. Studies suggest that women who experience major depression after childbirth often had previous episodes of depression that may not have been diagnosed and treated.

Women with infertility problems may feel extreme anxiety or sadness, although it is unclear if this contributes to a higher rate of depression. Motherhood may be a time of increased risk for depression because of the stress and demands it imposes on women.

### **GLBT**

For youth who have same-sex attractions or who identify as gay, lesbian, bisexual or transgender, adolescence can be a very turbulent time than usual as they cope with stigma and social prejudice related to their sexual orientation or gender identity.



The effects of this stigma may make GLBT youth more vulnerable to mental health problems such as depression, anxiety, substance abuse and suicide. For example, one study found that gay, lesbian and bisexual youth aged 14-21 were significantly more likely to report depression and anxiety than heterosexual peers. An even more serious concern is the issue of suicide and GLBT youth. A recent review of the literature suggests that suicide attempts among GLBT youth are 20-40 percent higher than among non-GLBT youth. This is a function of such things as negotiating coming out, fear of or actual familial disapproval and rejection, victimization by peers, and the chronic stress associated with having a stigmatized identity.

#### **Tips for Finding a GLBT-friendly health care provider:**

- Ask for referrals. Talk to your peers or visit your local GLBT community center. You could also check the Web sites for the Association of Gay and Lesbian Psychiatrists: [www.aglp.org](http://www.aglp.org) or the Gay and Lesbian Medical Association: [www.glma.org](http://www.glma.org).
- Call and ask questions. Ask health care providers if they have any GLBT patients, if they have received any GLBT cultural competence training, and if they provide a safe space for GLBT individuals.
- Assess the health care provider. Did he seem at ease with you? Did she talk openly about your sexuality or gender identity? Did you feel comfortable? Could have an open discussion?

## Causes

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 be 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.

The occurrence of mood disorders and suicides tend to run in families. In the case of complete genetic inheritance, such as with identical twins, it appears, however, that only about 30 percent of the time when one twin develops depression will the other twin. 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, genetic tendency to develop depression will ever lead to an episode of major depression.

Certain aspects of life, such as marital status, financial standing and where a person lives, do have some bearing on whether someone develops depression, but it can be a case of "the chicken or the egg." 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. 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 genetic 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 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 genetic pathways.

## Treatment

Although depression can be a devastating illness, it often responds to treatment—the key is to get an specific evaluation and a treatment plan. Today, there are a variety of treatment options available for depression. There are three well-established types of treatment for depression: medications, psychotherapy and electroconvulsive therapy (ECT). A new treatment, called repetitive transcranial magnetic stimulation (rTMS), has recently been cleared by the FDA for individuals who have not done well on one trial of an antidepressant. For some people who have a seasonal component to their depression, light therapy may be useful. In addition, many people like to manager their illness through alternative therapies or holistic approaches, such as acupuncture, meditation and nutrition. These treatments may be used alone or in combination.

## Medications

Medications often effectively control the serious symptoms of depression but people with living with depression must also 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 support by people who have “been there,” supportive relationships, aerobic exercise and attention to co-occurring conditions are also useful in supporting recovery.

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, people may have to try various doses and different antidepressants before finding the

one or the combination that is most effective. Friends and relatives will sometimes notice an improvement on medication before the depressed person him- or herself will notice any changes. Antidepressant medications are not habit-forming, however they should not be stopped abruptly as withdrawal symptoms (muscle aches, stomach upset, headaches) may occur. Below is a list of medications.

**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, which increases levels of serotonin. SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa) and escitalopram (Lexapro). Common side effects of SSRIs include sexual dysfunction and gastrointestinal problems.

**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, which increases the amounts of these chemicals. SNRIs include venlafaxine (Effexor), desvenlafaxine (Pristiq) and duloxetine (Cymbalta).

**Bupropion (Wellbutrin)** is a popular antidepressant medication classified as a norepinephrine-dopamine reuptake inhibitor (NDRI). It acts by blocking the reuptake of dopamine and norepinephrine and increases these neurotransmitters in the brain. It also helps with smoking cessation strategies. Bupropion 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, bupropion causes significant anxiety symptoms and for others it is a very effective treatment for anxiety. However, bupropion has been shown to increase the likelihood of having a seizure in those prone to seizures, or at doses above 450mg per day and should never be taken at doses above the recommended maximum dose. Bupropion is not recommended in people with a history of an eating disorder, head injury or seizure disorder.

**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. Mirtazapine is used less

often than other, newer antidepressants (SSRIs, SNRIs, bupropion) because it is associated with more weight gain, 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.

**Atypical antipsychotics.** Aripiprazole (Abilify) and quetiapine (Seroquel) are atypical antipsychotics that were approved by the FDA in 2007, and used to augment depression when used along with antidepressants. The specific combination of olanzapine and fluoxetine (Symbyax) is also approved.

**Tricyclic antidepressants (TCAs)** are older agents seldom used today as first-line treatment. They work similarly to the SNRIs, but have other properties that often result in higher 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), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), nortriptyline (Pamelor, Aventyl) and protriptyline (Vivactil). TCAs (and duloxetine) may be helpful with chronic pain as well. 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 and weight gain or loss.

*Note: Although antidepressants generally reduce suicidal thoughts along with other symptoms of depression, children, adolescents, and young adults starting an antidepressant medication should be monitored frequently for the emergence or worsening of suicidal thoughts due to the possibility of increased suicidality in some young people who are taking antidepressant medication. The FDA public health advisory on this issue is available at [www.fda.gov](http://www.fda.gov).*

**Monoamine oxidase inhibitors (MAOIs)** are less commonly used today. MAOIs work by inactivating enzymes in the brain, which catabolize (breakdown) serotonin, norepinephrine and dopamine from the synapse, thus increasing the levels of these chemicals in the brain. They can never be used in combination with SSRI antidepressants. MAOIs can sometimes be effective for people who do not respond to other medications or who have “atypical” (abnormal) depression with marked anxiety, excessive sleeping, irritability, hypochondria or phobic

characteristics. They have important food and medication interactions, which requires strict adherence to a particular diet. MAOIs include phenelzine (Nardil), isocarboxazid (Marplan) tranylcypromine sulfate (Parnate) and selegiline patch (Emsam). Selegiline (Emsam) is a patch approved by the FDA in 2006. This delivery system reduces the risk of the dietary concerns noted above.

The FDA periodically approves medications. For a current list, visit [www.fda.gov](http://www.fda.gov).

## **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 10-20 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 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”), leading 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. In fact, one study found that psychodynamic psychotherapy was no more effective than placebo for depression.

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 and can 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 and for severe depression with psychosis. When medication and psychotherapy are not effective in treating severe symptoms—such as acute psychosis or thoughts of suicide—or if a person cannot take antidepressants, ECT may be considered. ECT can be combined with antidepressants for some individuals. Memory problems can follow ECT treatments, so a careful risk-benefit assessment needs to be made for this important and effective intervention.

### **Repetitive Transcranial Magnetic Stimulation (rTMS)**

In October 2008, the FDA cleared the use of rTMS for major depression. Early returns indicate it to be a low-risk intervention that may help a person who has not responded to one antidepressant trial. At this time, rTMS does not appear to be effective for major depression with psychotic features. More will be learned about this new treatment as research continues.

### **Complementary and Alternative Medicine (CAM)**

CAM refers to alternative forms of medicine that are not considered part of conventional (Western) medicine. In recent years, CAM has become increasingly popular, but no CAM strategy has won FDA approval. While there is still limited data showing support for many CAM practices and some

inconsistency in results, there studies which support the usefulness of CAM strategies that are considered to have minimal if any adverse effects. One practice that has shown some promise for the treatment and management of bipolar disorder, as well as other mental illnesses, are omega-3 fatty acids, which are commonly found in fish oil. Some researchers hypothesize that omega-3 may be beneficial in treating mental illness because of its ability to protect or support the replenishing of neurons and connections in areas of the brain that are affected by these illnesses. S-adenosylmethionine (SAM-e) has been shown to be effective in one study in combination with other antidepressants. St. John's Wort has been shown in several studies to not be better than a placebo.

### **Aerobic Exercise**

Studies and literature now support that aerobic exercise can aid in treating mild depression. A 2005 study at the University of Texas Southwest Medical Center was the first study to look at exercise alone in treating mild to moderate depression in adults aged 20-45 showed that depressive symptoms were reduced almost 50 percent in individuals who participated in 30-minute aerobic exercise sessions three to five times a week. Harvard Medical school notes exercise enhances the action of endorphins, and endorphins reduce the perception of pain as well as potentially have the ability to improve mood. In addition, exercise stimulates the neurotransmitter norepinephrine, which may directly improve a person's mood. For mild to moderate depression, aerobic exercise is usually a



key component to a treatment plan. For more on exercise and wellness, visit NAMI's Hearts & Minds program at [www.nami.org/heartsandminds](http://www.nami.org/heartsandminds).

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 multicenter trial funded by the National Institute of Mental Health (NIMH) called STAR\*D ([www.nimh.nih.gov/healthinformation/stard.cfm](http://www.nimh.nih.gov/healthinformation/stard.cfm)) 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 improved the treatment of clinical depression, particularly for those with more serious or recurrent forms of the disorder. A comprehensive array of treatments can be effective overall, and most people with biological depression get significant relief from medications—especially when the depression is moderate 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 one-half of people 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 saw 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.

## **Coping Strategies**

Leading a balanced lifestyle can help make living with depression more manageable. The strategies below are suggestions from real people who have had success in managing the illness.

### ***Become an expert***

There are many excellent sources of information on depression. Learn all you can about medications, keep up with current research and treatment options, attend local conferences and network with other people at meetings and support groups. Build a personal library of useful websites and helpful books.

### ***Recognize early symptoms***

Learning your pattern of symptom development is key. Identifying certain triggers, times of year or other factors that may aggravate symptoms may help identify an emerging episode. This can prompt more aggressive intervention to prevent the worsening of symptoms. Don't be afraid to ask the people around you for help—they can help monitor behavior.

### ***Engage in your treatment***

The relationship with your health care providers is fundamental to the successful management of major depression. To be partners, you both must develop a trust and a strong line of communication. Provide the information your health care provider needs to help you recover, including complete and honest reports about reactions to medications, improving or worsening symptoms and anything that could trigger a depressive episode.

### ***Develop a plan***

To reduce uncertainty and stress, know what to do in a crisis. Although it might be challenging to discuss your illness, get your loved ones, friends and health care providers to help. Most communities have a crisis hotline or emergency walk-in centers, so know where they are and keep them handy.

### ***Find support***

Emotional support from others living with depression is an important part of recovery. It is helpful to share thoughts, fears and questions with others who have the same illness. For more on NAMI support and education programs, see the resources section. Online message boards and groups found through social sites like meetup.com are good resources for connecting with others, too.

### ***Avoid alcohol and substances***

Drugs and alcohol disturb an already delicate emotional balance, and can also interact dangerously with medications. Both depression and mania make these drugs appear to be attractive options to “slow down” or “perk up,” but the potential damage will block your road to recovery.

### ***Get healthy***

Maintain a well-balanced diet and engage in regular exercise. This helps produce positive mental and physical health benefits. Try to incorporate low-key activities like meditation, yoga or Tai Chi into your life to help alleviate stress and achieve balance.

### ***Get involved***

If paid employment is not an option now, volunteer work can enrich your life, teach you useful skills and help create a sense of purpose and structure. Learning a new skill or immersing yourself in a hobby--particularly a creative one--can offer constructive alone time to help balance out a busy life. Engaging in your community—from coaching youth sports to helping your parks and neighborhoods stay clean and green—are all ways you can get involved with the world around you.

## **Friends and Family**

There are many actions a caregiver can take to provide help to a loved one living with depression. Offering emotional support, talking and listening carefully to what a loved one is experiencing and learning about the illness so you can understand what your friend or relative is experiencing are all great ways to be supportive.

Caregivers also need support and the opportunity to talk to people who understand and can help. It is common for both the person living with the illness and family members to experience grief because of the drastic changes in their lives and the trauma that previous episodes may have caused.

Individuals living with mental illness, and their families, must work together and discuss past episodes so that they can clearly recognize the early signs of a developing episode. Whatever the indicator of possible relapse is, everyone should agree on what the objective signs of a possible episode are.

## How to Talk to Someone about Depression

Ami Claxton Harris, M.S., Ph.D.

If you have a friend or relative who is depressed, it can feel uncomfortable or awkward to talk to them about depression. The last thing you want to do is say the wrong thing. However, no one ever defines the “wrong”—or the “right”—thing to say. Remember, too, that tone of voice makes a huge difference and that every person and every situation is unique.

### **“Wrong” things:**

#### **“But you have so much to be happy about.”**

I started with this one because this is the phrase I disliked hearing most. I know what good things are in my life, and I still feel depressed despite all of these good things. In fact, this statement nearly always has the opposite of its intended effect. Here is instead what I heard: “You have all these great things in your life and you’re still depressed? You must be ungrateful and something is really wrong with you.” It ends up feeling like an accusation rather than the comfort it is intended to be. I am aware of these good things, but am hurting in spite of all the good things in my life.

#### **“You can get through this, you are so strong.”**

No, I’m not, or I wouldn’t feel this way. I may become strong again some day, but right now, I’m not strong. I’m weak and I need help. And that’s okay.

#### **“I know how you feel.”**

No, you don’t. This nearly always comes off as condescending unless you have personally been through a true, deep, clinical depression in your past.

#### **“How are you?”**

Unless you are passing me in the produce aisle, please don’t ask me how I’m doing. I’m not doing well, and if you ask me, I’ll lie and answer automatically that I’m fine.

#### **“You just need to look at the bright side and try harder.”**

If that actually worked, I would have already done it. Variations of this include “You need to just get yourself together!” or “Just take a deep breath.” Breathing deeply doesn’t help the dark thoughts, the feelings of despair and the utter lack of joy that I feel. And I can’t get myself together—that is the very root of the problem.



### **“Right” things:**

**“It’s okay to not be strong right now, let me be strong for you.”**

This felt good. I felt like I could let my guard down and allow myself to feel weak and vulnerable while knowing that I was still loved. Being able to relax while knowing that I had a safety net helped tremendously.

**“I have experienced depression myself.”**

Knowing that you are willing to share your experience—and willing to ignore the stigma associated with depression and mental illness—makes a big difference. If you are currently being treated or have been treated in the past (medication, talk therapy, etc.) for depression or any mental illness, please say so! It makes me feel less alone and less “crazy.” On the other hand, if you haven’t personally experienced it, do not tell me about how sad you were when your bird died, or about your second cousin Sally’s depression (unless you were intimately involved in her recovery process). To do so can come off as insincere or flippant.

**“Tell me how it feels for you right now.”**

Instead of a “How are you,” ask how I am using other words, more specific words. “How are you?” will elicit “Fine” almost by reflex. When queried more specifically, you may get a more honest answer such as “I feel numb,” or “I feel scared and sad.” Naming feelings can be liberating, and it’s comforting to know that someone is interested in the real response.

**“I admire your courage.”**

It takes a huge amount of courage to tell someone that you are depressed. Acknowledging that fact is probably the single most important thing that can be done.

**“I’d like to help. May I (fill in the blank with something highly specific)?”**

Everyone says “Let me know if I can do anything to help.” Usually, no one actually means it. And even among those who do mean it, asking for help is difficult even when things are going well, and it’s exceptionally difficult to ask for help when depressed. So, instead say “I’d like to help you. Can I drop off dinner for you on Wednesday?” “Could I walk your dog for you tomorrow morning?” Or “I’d like to help, so on Tuesday afternoon, can I pick your child up at school and have him play with my kids until 5?” Be extremely specific. Overly, ridiculously specific. Make it as easy as possible for the person who is depressed to simply agree to be helped. Make it specific, make it soon and make it easy to just say yes.

**“I want you to know that I care about you.”**

I saved the best and most important for last. If you say nothing else, say this. In fact, you could say absolutely everything on the “wrong” list, but if you say this, that’s all that really matters.

Among those who are at risk for suicide, there are a few more good things to say. However, if you are dealing with someone with suicidal depression, never, ever go it alone. First and foremost, be sure that person has a doctor and/or a therapist. Ensure there are other friends and family members who are checking in with that person frequently. Remember that no one untrained person can possibly be equipped to serve as a suicide prevention plan—that’s too much on anyone’s shoulders. But do let that person know that you recognize they could be a suicide risk, that you love them, and that you want them to be alive.

**“Do not kill yourself.”**

Believe it or not, this direct statement has a huge impact. Do not preface it with please. Leaving please off turns it from a request to a command. Sometimes it is easier to just blindly obey than to comply with a request.

**“I am going to call you at 8 p.m. tonight.”**

For those in serious danger, giving a short timeline to a small event can be a lifeline. Be completely sure that you follow

through. The key here is a short timeline (e.g. less than 24 hours) and being specific about the action (e.g. sending an email, instant messaging, stopping by, calling, etc.).

**“I value your life and want you to be part of my life.”**

When suicidal, by definition one doesn't value his or her life. Knowing someone else values it matters.

## Becoming an Advocate

Becoming an advocate means working to change the world, starting with oneself. Advocates change what they can, beginning with small, everyday problems but dreaming big. There are numerous social issues that are related to mental illness and depression in particular:

- Funding for treatment, including new treatments and disparities
- Homelessness
- Funding for research
- Supported employment
- State health care budgets
- Criminalization of people living with mental illness

Learn about these issues and how to encourage policy makers to take action on them in NAMI's Legislative Action Center at [www.nami.org/advocacy/policy](http://www.nami.org/advocacy/policy).

For years in this county, mental health care services have fallen short when it comes to the support and treatment of individuals living with mental illness. It is very important to make sure competent care is available in your state. For more information on budget cuts and policy and laws in your state as well as the federal level, visit [www.nami.org/policy](http://www.nami.org/policy).

Participation in research studies is another way to take an active part in improving options for people living with depression. Scientists need volunteers from all backgrounds to volunteer for studies. [ClinicalTrials.gov](http://ClinicalTrials.gov) is one resource for finding these opportunities and [www.nami.org/research](http://www.nami.org/research) also lists research studies.

*Written by Ken Duckworth, M.D., NAMI medical director, with additional writing and guest editing by Dr. Richard Shelton (Vanderbilt University).*

## Resources

### **National Institute of Mental Health (NIMH)**

[www.nimh.nih.gov](http://www.nimh.nih.gov)

### **Depression and Bipolar Support Alliance**

[www.dbsalliance.org](http://www.dbsalliance.org)

**www.nami.org** features the latest information on mental illnesses, medication and treatment and resources for support and advocacy. Other features include online discussion groups and fact sheets.

**StrengthofUs.org** is an online social community for teens and young adults living with mental illness, is a place where they can connect while learning about services, supports and handling the unique challenges and opportunities of transition-age years.

**NAMI HelpLine** receives more than 8,000 requests each month from individuals needing support, referral and information. More than 60 fact sheets on a variety of topics are available along with referrals to NAMI State Organizations and NAMI Affiliates in communities across the country.

[www.nami.org/helpline](http://www.nami.org/helpline) • (800) 950-NAMI (6264)

**NAMI Hearts & Minds** is an online, interactive wellness educational initiative intended to promote quality of life and recovery for individuals who live with mental illness. Focuses include exercise, nutrition and smoking cessation.

[www.nami.org/heartsandminds](http://www.nami.org/heartsandminds)

**NAMI Peer-to-Peer** is a free, 10-week education course on the topic of recovery for any person living with a serious mental illness. Led by mentors who themselves have achieved recovery, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills and self-care. [www.nami.org/peertopeer](http://www.nami.org/peertopeer)

**NAMI Family-to-Family** is a free, 12-week course for family caregivers of adults living with mental illness. An evidence-based practice taught by trained NAMI family members who have relatives living 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. Also available in Spanish. [www.nami.org/familytofamily](http://www.nami.org/familytofamily)

**NAMI In Our Own Voice** is a public education presentation. It enriches the audiences' understanding of how the more than 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, last 60-90 minutes and is offered free of charge.

[www.nami.org/ioov](http://www.nami.org/ioov)

**NAMI Connection** is a recovery support group for adults living 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 living with mental illness face. [www.nami.org/connection](http://www.nami.org/connection)

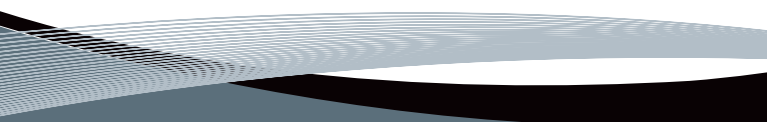
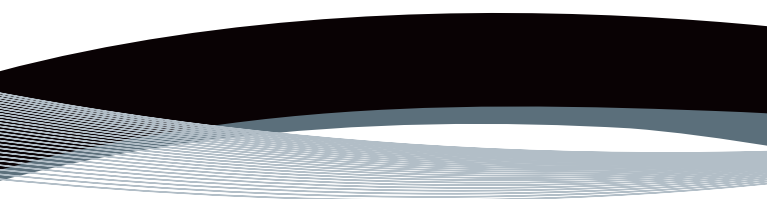
**NAMI Basics** is a free, educational program for parents and other primary caregivers of children and adolescents living with mental illness. The course is presented in six different classes, provides learning and practical insights for families and is taught by trained parents and caregivers who have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

[www.nami.org/basics](http://www.nami.org/basics)



**National Alliance on Mental Illness**

*Find help. Find hope.*



[www.nami.org](http://www.nami.org)

[www.facebook.com/officialnami](https://www.facebook.com/officialnami)

Twitter: [NAMICommunicate](https://twitter.com/NAMICommunicate)

(800) 950-NAMI (6264)