OLC #2: The Least Depressing OLC On Depression You'll Ever Take

3 Contact Hours / $6.00
Approvals: NBCC ACEP # 6489; TX PAP LPC # 1482; TX PAP SW # 5915

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The certificate will indicate that this course was taken on-line.

Course Description

This on-line course will provide information related to depression in a variety of methods. Additionally, it will provide knowledge and information aimed at helping mental health professionals increase their level of competency in working with clients who are affected by depression. The areas this on-line course will attempt to address include the following:

-Causes: brain chemistry vs. life stressors

-Treatments: the old stand-by's and the newest treatments available as of the writing of this course

-The neuroscience of depression

-Who is most likely to become depressed?

-Once depressed, always depressed?

-Things we might not realize cause depression

-Anti-depressants: the good, the bad, and the downright wrong

-Where we're incorrect about depression

-Uses of tests and/or quizzes

-Hit or miss treatment: is this really ethical?

-Depression and the anxiety link

-What helps the most?

-The work of Dr. Helen Mayberg at Emory University, Atlanta, GA

-Treatments: the old stand-by's and the newest treatments available as of the writing of this course

This on-line course will also include salient and potentially life-saving information related to 11 specific areas associated with depression. Each area will be identified by its number within the 11 areas.

Additionally, to increase the learner's experience, it is imperative that she/he watch the videos that are part of this on-line course. While they are considered by this author as mandatory, we all know that I cannot enforce this. Please keep in mind that the organizations that have approved this on-line course for use as continuing education are counting the videos as part of the way the number of ceu's are determined. In other words, think about the ethical issue involved should one choose not to watch the videos.

Here is something else to consider: if you decide to skip the videos, picture in your mind someone struggling with depression, someone who has truly lost all hope. That person may be a client, a family member, or perhaps yourself. That may be enough incentive for you to choose to watch these videos.

Each video is thoroughly described. Some of these professionals have additional videos on other topics. You will know you have the correct video for this on-line course by checking the length shown and by being sure the title is what I have listed on each video put in this course for your benefit and for the benefit of those whose lives your knowledge and information about depression may affect. Many of these videos are on TED.com and are also on YouTube.com. Some of these videos are only on YouTube.com There is 1 article I have recommended. It is listed after Video # 6. The article is counted as number of words. The videos are counted by how long each video is. (the number of minutes)

Target Audience:

Licensed mental health care providers who by the nature of their work, come into contact with clients who are struggling in various degrees with depression and with various diagnoses of depression. The course objectives for this on-line course will address the following areas related to depression and their effect on the clients of mental health professionals and on increasing the knowledge and competency of mental health professionals.

Course Objectives:

At the completion of this on-line course, the mental health professional will have been provided with the opportunity to be able to do the following:

- identify a minimum of 2 of the newest treatments of depression
- describe a minimum of 4 ways that depression interferes with one's daily functioning
- articulate a statement that differentiates depression from sadness
- enumerate a minimum of 3 drugs that contribute to depression
- list at least 3 of the currently assumed causes of depression
- name a minimum of 3 facts related to the neuroscience of depression
- complete the exit quiz with a score of at least 80%

DESCRIPTION OF VIDEOS AND METHODS OF LOCATING THEM. THE VIDEOS MAY BE WATCHED AT ANY TIME. THEY ARE NOT 'TIED' TO ANY PARTICULAR PART OF THE COURSE. THE ARTICLE MAY BE READ AT ANY TIME.

Video # 1: This is the title of the video: Sherwin Nuland: How electroshock therapy changed me Go to Ted.com and in the top right you'll see a box that says Search. Enter Sherwin Nuland. This is a 23 minute video that will add a dimension to the experience of depression that most clinicians never know about. It's possible that the title itself is hot for you. Try it and see. This video is also on YouTube. **As an aside, Dr. Nuland died in March of 2014. His obituary is absolutely inspiring.

Video # 2: The title of the video is: David Anderson: Your brain is more than a bag of chemicals Go to Ted.com and in the top right you'll see a box that says Search. Enter David Anderson. This is a 15 minute video. You will never look at fruit flies the same way again. Seriously. He also gives one of the most powerful analogies regarding depression I've ever heard: "Trying to treat depression with drugs is like trying to change the oil in your car by pouring oil all over the engine." Think about it. It's possible that the title itself is hot for you. Try it and see. This video is also on YouTube.

Video # 3: The title of the video is Andrew Solomon: Depression, the secret we share Go to Ted.com and in the top right you'll see a box that says Search. Enter Andrew Solomon. This is a 28 minute video that will drive you to want to do all you can to increase your knowledge of depression and your desire to help those affected by it. This is one of the most helpful videos I've ever seen in the area of depression. Here is the description taken from the information about this video on Ted.com: "In a talk equal parts eloquent and devastating, writer Andrew Solomon takes you to the darkest corners of his mind during the years he battled depression. That led him to an eye-opening journey across the world to interview others with depression — only to discover that, to his surprise, the more he talked, the more people wanted to tell their own stories." Here is a direct quote from Andrew Solomon that you may find very powerful to consider as you learn more about depression and more about how to be as helpful and knowledgeable as possible when working with clients who are experiencing depression: "The opposite of depression is not happiness, but vitality, and it was vitality that seemed to seep away from me in that moment." It's possible that the title itself is hot for you. Try it and see. This video is also on YouTube.com along with several other videos on aspects of depression by Andrew Solomon.

Video # 4: The title of the video is Jane McGonigal: The game that can give you 10 extra years of life Go to Ted.com and in the top right you'll see a box that says Search. Enter Jane McGonigal. This video is only 11 minutes long, but you will feel like you have been at a workshop that supplied you

with a year's worth of information related to depression and creative ways to work with it. Here's the description: "When game designer Jane McGonigal found herself bedridden and suicidal following a severe concussion, she had a fascinating idea for how to get better. She dove into the scientific research and created the healing game, SuperBetter. In this moving talk, McGonigal explains how a game can boost resilience -- and promises to add 7.5 minutes to your life."

It's possible that the title itself is hot for you. Try it and see. Here's another possible link that may work for you:

http://www.ted.com/talks/jane_mcgonigal_the_game_that_can_give_you_10_extra_years_of_life This video is also on YouTube.com

Video # 5: The title of the video is JD Schramm: Break the silence for suicide attempt survivors Go to Ted.com and in the top right you'll see a box that says Search. Enter JD Schramm. This is not a typo. There are no periods after his initials. Here's the description: "Even when our lives appear fine from the outside, locked within can be a world of quiet suffering, leading some to the decision to end their life. At TEDYou, JD Schramm asks us to break the silence surrounding suicide and suicide attempts, and to create much-needed resources to help people who reclaim their life after escaping death." It's possible that the title itself is hot for you. Try it and see. This video is 5 minutes long. Here's another possible link that may work for you: **http://www.ted.com/talks/jd_schramm** This video is also on YouTube.com

Video # 6: The title of the video is Depression Biomarker Study: Using Brain Scans to Help Choose Treatment Type. This is the Dr. Helen Mayberg video and here's the YouTube location: **http://youtu.be/7eACXXlQFq0** . This video is on YouTube.com. This video is 5 minutes long. It's a powerful piece of cutting edge information. This is one of many videos that looks at the work of Dr. Helen Mayberg, a renowned researcher in the area of depression

Video # 7: The title of this video is Deep Brain Stimulation for Depression. This is another video demonstrating the use and effects of Deep Brain Stimulation. This video is 8 minutes long. It contains additional information of the work of Dr. Helen Mayberg and was presented by Anderson Cooper on a CNN report. Here is the link:
https://www.youtube.com/watch?v=9uur4jNX4AM

Video # 8: The title of this clip is Deep Brain Stimulation for Depression CNN Presents Special with Dr. Sanjay Gupta. This is a 13 minute video. Dr.

Gupta explains for the lay public the uses of Deep Brain Stimulation. Also presented is a patient having the procedure. Excellent, non-technical, easy for all video clip. Here is the link:
https://www.youtube.com/watch?v=Lq5rIILcVgA

Article # 1: The title of this article is 'Is Ketamine the Next Great Depression Drug?'

I would simply enter the following **http://america.aljazeera.com/watch/shows/america-tonight/articles/2015/2/12/Ketamine.html** in your browser. You should go straight to this article. The title above maybe be hot for you. If this link does not take you to the article, simply put the article title in google. You should be able to locate it that way.

Facts about depression: As if depression weren't bad enough, statistics show that diagnoses of depression are growing at an alarming rate. In addition, states with higher rates of depression also show high rates of other negative health outcomes, such as obesity, heart disease, and stroke. Individuals suffering from depression are more likely to be unemployed or recently divorced than their non-depressed counterparts, and women experience greater risk of depression than men. Despite all of these statistics on depression many people suffer symptoms of depression without seeking care. It is so crucial to keep in mind that undiagnosed depression costs the U.S. millions of dollars each year. Depression is now considered a global health issue. Depression awareness, diagnosis, and treatment are matters of the utmost significance in building a healthier, happier world.

We have an oversimplified and increasingly outmoded view of the biological basis of psychiatric disorders. It is imperative to point out that the traditional view of the causes of depression is that there is a chemical imbalance in the brain. This is increasingly considered to be an outdated view. The view that is becoming more strongly and accurately considered is that there is a disruption in the neural circuitry of the brain that mediates emotion, mood, and affect. Treatment will be decided depending on which view the mental health professional believes. In fact, all decisions regarding treatment of psychiatric disorders are generally chosen based on the beliefs of the professional. A profound question that has been asked but never answered is

this: what if the professional's belief about a particular treatment is incorrect or rather, what if the treatment is totally ineffective yet the professional's belief in the treatment has not been examined, proven, or challenged? There is a huge ethical issue with treatment such as this, yet it is allowed to continue.

In this on-line course you will find below 11 specific areas associated with depression that must be addressed in order to help all mental health professionals become more knowledgeable in their understanding of how to work more effectively with clients who have a diagnosis of depression. A mental health professional who does not understand these areas is significantly more likely to do more harm than good in working with clients who are experiencing depression. These areas are not meant to be a complete examination of the information related to that area. Mental health professionals must commit to doing their own reading and researching of these areas.

Mental Health Professionals Must:

1. **Understand the effects of depression**: depression brings about high rates of other negative health outcomes, such as obesity, heart disease, and stroke. Individuals who are suffering from depression are more likely to be unemployed or recently divorced than their non-depressed counterparts. Thus we begin to see the vicious cycle depression can bring about.

2. **Stop underestimating the vast number of people struggling with some form of depression:** first, clients have the right to a correct diagnosis. When attempting to diagnose depression, many, many uninformed mental health professionals give their clients a questionnaire. Is this really an effective way to diagnose depression? Most people would not want a diagnosis of the problem with their brains that was arrived at by completing a questionnaire. So, what we have is incorrect diagnoses and undiagnosed depression, both of which cost the U.S. millions of dollars each year, destroy lives, relationships, families, and take a terrible toll on human suffering. These mistakes can be avoided by making superior information about depression and how to recognize it available in as many areas as

possible and to as many people as possible, in both the lay public and the therapeutic community alike.

In order to move closer to truly grasping the epidemic of depression, there must be an understanding of the difference between sadness and depression. Although depression is often thought of as being an extreme state of sadness, there is a huge difference between sadness and clinical depression. Sadness is a part of being human -- a natural reaction to painful circumstances. All of us will experience sadness at some point in our lives. Depression, however, is a physical illness with many more symptoms than an unhappy mood. Often depression may be accurately diagnosed by educating people about what constitutes depression, meaning that people are provided with accurate information from which to draw on to get an idea about if depression may or may not be present in their lives. We must, however, keep in mind that for many that alone does not work. We will address other methods further along in this course.

3. **Address the question about whether or not there a "best" treatment for depression:** the answer to this question depends on who you ask. There are too many treatments for depression to even begin to address in this course, some with clinical research behind them and some with the testimony of a person who was helped by whatever the treatment was and some touted by the pharmaceutical company that produced a particular drug. The best treatment is the one that works. However, this introduces three important questions: 1. How do you know which one will work? 2. Who do you trust to advise someone about treatments? 3. How do we help our clients find the answer to Questions # 1 and # 2? Inherent in these 3 questions is the following statement: **Psychiatrists are the only physicians who are allowed to guess at treatment for their patients.** Think about this. If you go to your internist, she or he would probably lose the license to practice medicine if treatment were arrived at by guessing. Yet, this is how the psychiatric professions seems to work. Have you ever noticed when working with clients who are experiencing depression, that the client may have tried anywhere from 2 to 8 anti-depressants, with the ***hope*** that one might work?

4. **Get around the exercise dilemma:** Any therapist who has worked with clients experiencing depression knows that exercise is a proven help in treating depression. Any therapist who has worked with clients experiencing depression also knows that the last thing someone who is depressed wants to do is exercise. Think about this: "If I exercise, I'll feel better, but I don't feel good enough to exercise." Here we have the classic Catch-22. Here is one way I personally have found helpful in working with clients experiencing depression: get out and walk with your clients. This means getting out of the box that says therapy can only occur in an office setting. Certainly the therapist would want to insure that all things involved in doing this are addressed before taking a client out to walk with her/him. Areas such as fitness for exercise, type of exercise (walking vs. power walking as one of many examples), location, fitness level of client and fitness level of therapist, approval from supervisor if the therapist works for an agency or organization, and most importantly, the willingness and cooperation of the client must be addressed. Certainly involvement of a physician is crucial. Documentation must be thorough.

5. **Understand how to work with the client regarding the stopping meds 'because I feel better' dilemma:** Here is one idea that many therapists have found useful in dealing with this dilemma: have the client commit to reading 1 article regarding depression before coming to the session. Both therapist and client would read the same article, meaning that the client might choose the article and let the therapist know so that the therapist can access that article or the article is chosen by the therapist. Why? Because it keeps the client involved in the therapeutic process long enough to see that there is an issue when medication is stopped because 'I feel better'. The "I feel better' mood is not going to last, at least not by stopping treatment at the drop of a hat. There is a possibility that the client truly does feel better and that the feeling will last, but without continuing therapeutic contact with the client, the therapist will not know what is happening with the client: has the client begun experiencing depression again? Is the client functioning in an acceptable manner? The therapist must know the outcome of a client stopping her/his treatment because of feeling better. In other words, just because a client says "I feel great so I stopped taking those medications with those terrible side effects," does not by any means signal that counseling then ends. In fact, this is one place where

therapy must not end. To repeat: without continuing therapy (for how much longer must be a mutual decision made by the therapist and the client) has the client begun experiencing depression again? Is the client functioning in an acceptable manner? The therapist must know the outcome of a client stopping her/his treatment because of feeling better. As an additional point of information, anti-depressants are very strong and powerful medications. If stopped without the supervision and input of a licensed physician, many of these drugs can cause dangerous and possibly life threatening situations.

6. **Become exceptionally mindful about how often we use the word "depressed" inaccurately:** therapists must be willing to educate the public about the difference between the terms depressed and sad and also about the different types of depression. They must also be willing to understand this information themselves. It's virtually impossible to share correct information when the information you are sharing is incorrect. It is imperative that therapists model correct use of terms.

7. **Recognize how often others minimize someone's depression:** there is not always a logical reason for people's dark feelings. Exhortations from well-meaning friends and family for the person to "snap out of it" provide only frustration for the person experiencing depression. That person can no more "snap out of it" than diabetics can will their pancreases to produce more insulin. Again, it is imperative that therapists provide correct information to the family and friends about this. Relieving frustration that the client feels because of the pressure to "snap out of it" is in itself most likely to be helpful to the client as this can take pressure and blame off the client.

8. **Be aware of the help and also the possible pitfalls of using tests/quizzes/inventories related to depression:** Tests, quizzes, and inventories abound. There are TONS of them. Unfortunately, many of them are found in magazines available at the check-out line at the local grocery store. How accurate are these tests, quizzes, and inventories? One thing to consider in trying to evaluate their help and accuracy is to use only ones that are based on statistical and research based information. Unfortunately, however, the vast majority of these tests, quizzes, and inventories are self-report. We

always have self-report, but we all know that is not always the most reliable way to ascertain how effective these tests, quizzes, or inventories are. Again, it is crucial that we keep in mind to use only instruments that have sound research behind them.

9. **Provide examples of helpful ways for family/friends to assist their family member or friend:**
   The mental health professional must help family and friends of the client to become very aware that what they say and how they say it matters. The therapist must include family and friends, obviously appropriately and ethically, in the treatment of the client struggling with depression. What is positively done in a session can be undone quickly by the client's family and/or friends.

   10. One size does not fit all: Everyone's experience of depression is different. This is why understanding that there are many different forms and types of depression is paramount for the mental health professional so that information can be shared with the client and with those who are affected by the depression the client is experiencing. Mental health professionals must keep abreast of the opportunities available to the client and to the client's family and friends to learn more about depression in all its forms and types. This may include, but is not limited to sharing pamphlets and other forms of printed information as well as knowledge of or about group meetings or professional lectures and/or presentations.

   11. Imbue hope: Imbue means to cause (someone or something) to be deeply affected by a feeling or to have a certain quality; to inspire, as with positive feelings, opinions. Dr. Irvin Yalom has stated that his first goal in therapy is to imbue hope. Without hope, there is nothing. Without hope, why bother? Many mental health professionals have a difficult time answering this question from a client: "Am I always going to feel like this? Is there any hope for me to improve?" Mental health professionals are not psychics, but they are aware that what they say can impact the life of the client significantly and they are aware they must be truthful. How does this response work for you: "I don't know, but I do know that new treatments are being worked on and are coming out often. Depression is a disease that many, many professionals are constantly

working to understand and to treat. Is there hope that you will improve? Yes, I believe there is hope you will improve. This is different from telling you I know beyond a shadow of a doubt that you will never have to experience depression again. But, again, keep in mind how much research is being done and how far treatment of depression has come over the years. Yes, I believe there is reason for hope." Of course, you would not say this if you did not believe it and if you did believe this, I am sure you would want to put it in your own words. Personally, I do believe this and the above quoted paragraph is what I say to my clients when I am asked those kinds of questions by them.

What Are the Main Causes of Depression?

There are a number of factors that may increase the chance of depression, including the following:

- **Abuse.** Past physical, sexual, or emotional abuse can cause depression later in life.
- **Conflict.** Depression in someone who has the biological vulnerability to develop depression may result from personal conflicts or disputes with family members or friends.
- **Death or a loss.** Sadness or grief from the death or loss of a loved one, though natural, may increase the risk of depression.
- **Genetics.** A family history of depression may increase the risk. It's thought that depression is a complex trait that may be inherited across generations, although the genetics of psychiatric disorders are not as simple or straightforward as in *purely* genetic diseases such as Huntington's chorea or cystic fibrosis.
- **Major events.** Even good events such as starting a new job, graduating, or getting married can lead to depression. So can moving, losing a job or income, getting divorced, or retiring.
- **Other personal problems.** Problems such as social isolation due to other mental illnesses or being cast out of a family or social group can lead to depression.
- **Serious illnesses.** Sometimes depression co-exists with a major illness or is a reaction to the illness.
- **Substance abuse.** Nearly 30% of people with substance abuse problems also have major or clinical depression.

How Is Biology Related to Depression?

Researchers have noted differences in the brains of people who are depressed as compared to people who are not. For instance, the hippocampus, a small part of the brain that is vital to the storage of

memories, appears to be smaller in some people with a history of depression than in those who've never been depressed. A smaller hippocampus has fewer serotonin receptors. Serotonin is one of many brain chemicals known as neurotransmitters that allow communication across circuits that connect different brain regions. Scientists do not know why the hippocampus may be smaller in some people with depression. Some researchers have found that the stress hormone cortisol is produced in excess in depressed people. These investigators believe that cortisol has a toxic or "shrinking" effect on the development of hippocampus. Some experts theorize that depressed people are simply born with a smaller hippocampus and are therefore inclined to suffer from depression. There are many other brain regions, and pathways between specific regions, thought to be involved with depression, and likely, no single brain structure or pathway fully accounts for clinical depression.

One thing is certain -- depression is a complex illness with many contributing factors. The latest scans and studies of brain chemistry suggest that antidepressants can help sustain nerve cells and allow them to form stronger connections that withstand biological stresses (called "neurotrophic effects"). As scientists gain a better understanding of the causes of depression, health professionals will be able to make better "tailored" diagnoses and, in turn, prescribe more effective treatment plans.

How Is Genetics Linked to the Risk of Depression?

We know that depression can sometimes run in families. This suggests that there's at least a partial genetic link to depression. Children, siblings, and parents of people with severe depression are somewhat more likely to suffer from depression than are members of the general population. Multiple genes interacting with one another in special ways probably contribute to the various types of depression that run in families. Yet despite the evidence of a family link to depression, it is unlikely that there is a single "depression" gene, but rather many genes that each contribute small effects toward depression when they interact with the environment.

Certain Drugs That May Cause Depression

The following drugs have been reported to cause depression in some patients. Elderly people are particularly at risk.

- Accutane: This drug treats severe acne.
- Alcohol
- Anticonvulsants: Anticonvulsants are used to control epileptic seizures, examples include Celontin and Zarontin.
- Barbiturates: These are a group of central nervous system depressants that slow down brain function. These medicines have been used to treat anxiety and to prevent epileptic seizures. They are commonly abused; examples are phenobarbital and secobarbital.
- Benzodiazepines: This group of central nervous system depressants is often used to treat anxiety and insomnia and to relax muscles; examples include Ativan, Dalmane, Halcion, Klonopin, Librium, Valium, and Xanax.
- Beta-adrenergic blockers -- Also known as beta-blockers, these medicines are used in the treatment of various heart problems, including high blood pressure, heart failure, chest pain caused by angina, and certain abnormal heart rhythms. They may also be used to treat migraine headaches; examples include Lopressor, Tenormin and Coreg.
- Calcium-channel blockers: This group of medicines slows the heart rate and relaxes blood vessels. Calcium channel blockers are used to treat high blood

pressure, chest pain, congestive heart failure, and certain abnormal heart rhythms, examples include Calan, Cardizem, Tiazac, and Procardia.
- Interferon alfa: This drug is used to treat certain cancers as well as hepatitis B and C.
- Norplant: This is a medicine used for birth control.
- Opioids: This group of narcotics is used to relieve moderate to severe pain. These drugs have a high potential for abuse and addiction; examples include codeine, morphine, Demerol, Percodan, and OxyContin.
- Statins: These medicines are used to lower cholesterol, protect against damage from coronary artery disease, and prevent heart attacks; examples include Mevacor, Zocor, Pravachol, Lescol, and Lipitor.
- Varenicline: A medication prescribed for smoking cessation.
- Zovirax: Doctors prescribe this drug to treat shingles and herpes.

Who Is Affected by Depression?

- Major depressive disorder affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population age 18 and older, in a given year. (Archives of General Psychiatry, 2005 Jun; 62(6): 617-27)
- While major depressive disorder can develop at any age, the median age at onset is 32. (U.S. Census Bureau Population Estimates by Demographic Characteristics, 2005)
- Major depressive disorder is more prevalent in women than in men. (Journal of the American Medical Association, 2003; Jun 18; 289(23): 3095-105)
- As many as one in 33 children and one in eight adolescents have clinical depression. (Center for Mental Health Services, U.S. Dept. of Health and Human Services, 1996)
- People with depression are four times as likely to develop a heart attack than those without a history of the illness. After a heart attack, they are at a significantly increased risk of death or second heart attack. (National Institute of Mental Health, 1998)

Depression often co-occurs with other illnesses and medical conditions.

- Cancer: 25% of cancer patients experience depression. (National Institute of Mental Health, 2002)
- Strokes: 10-27% of post-stroke patients experience depression. (National Institute of Mental Health, 2002)
- Heart attacks: 1 in 3 heart attack survivors experience depression. (National Institute of Mental Health, 2002)
- HIV: 1 in 3 HIV patients may experience depression. (National Institute of Mental Health, 2002)
- Parkinson's Disease: 50% of Parkinson's disease patients may experience depression. (National Institute of Mental Health, 2002)
- Eating disorders: 50-75% of eating disorder patients (anorexia and bulimia) experience depression. (National Institute of Mental Health, 1999)
- Substance use: 27% of individuals with substance abuse disorders (both alcohol and other substances) experience depression. (National Institute of Mental Health, 1999)
- Diabetes: 8.5-27% of persons with diabetes experience depression. (Rosen and Amador, 1996)

Depression and the Elderly

- About six million people are affected by late life depression, but only 10% ever receive treatment. (Brown University Long Term Care Quarterly, 1997)
- Fifteen to 20% of U.S. families are caring for an older relative. A survey of these adult caregivers found that 58% showed clinically significant depressive symptoms. (Family Caregiver Alliance, 1997)

Women and Depression

- Women experience depression at twice the rate of men. This 2:1 ratio exists regardless of racial or ethnic background or economic status. The lifetime prevalence of major depression is 20-26% for women and 8-12% for men. (Journal of the American Medical Association, 1996)
- Postpartum mood changes can range from transient "blues" immediately following childbirth to an episode of major depression and even to severe, incapacitating, psychotic depression. Studies suggest that women who experience major depression after childbirth very often have had prior depressive episodes even though they may not have been diagnosed or treated. (National Institute of Mental Health, 1999)
- Depression may increase a woman's risk for broken bones. The hip bone mineral density of women with a history of major depression was found to be 10-15% lower than normal for their age--so low that their risk of hip fracture increased by 40% over 10 years. (National Institute of Mental Health, 1999)

Economic Impact of Depression

- Major depressive disorder is the leading cause of disability in the U.S. for ages 15-44. (World Health Organization, 2004)
- Major depression is the leading cause of disability worldwide among persons five and older. (World Health Organization, "Global Burden of Disease," 1996)
- Depression ranks among the top three workplace issues, following only family crisis and stress. (Employee Assistance Professionals Association Survey, 1996)
- Depression's annual toll on U.S. businesses amounts to about $70 billion in medical expenditures, lost productivity and other costs. Depression accounts for close to $12 billion in lost workdays each year. Additionally, more than $11 billion in other costs accrue from decreased productivity due to symptoms that sap energy, affect work habits, cause problems with concentration, memory, and decision-making. (The Wall Street Journal, 2001, National Institute of Mental Health, 1999)

Depression and Suicide

- Depression is the cause of over two-thirds of the 30,000 reported suicides in the U.S. each year. (White House Conference on Mental Health, 1999)
- For every two homicides committed in the United States, there are three suicides. The suicide rate for older adults is more than 50% higher than the rate for the nation as a whole. Up to two-thirds of older adult suicides are attributed to untreated or misdiagnosed depression. (American Society on Aging, 1998)
- Untreated depression is the number one risk for suicide among youth. Suicide is the third leading cause of death in 15 to 24 year olds and the fourth leading cause of death in 10 to 14 year olds. Young males

age 15 to 24 are at highest risk for suicide, with a ratio of males to females at 7:1. (American Association of Suicidology, 1996)

- The death rate from suicide (11.3 per 100,000 population) remains higher than the death rate for chronic liver disease, Alzheimer's, homicide, arteriosclerosis or hypertension. (Deaths: Final Data for 1998, Center for Disease Control)

Treatment for Depression

- Up to 80% of those treated for depression show an improvement in their symptoms generally within four to six weeks of beginning medication, psychotherapy, attending support groups or a combination of these treatments. (National Institute of Health, 1998)
- Despite its high treatment success rate, nearly two out of three people suffering with depression do not actively seek nor receive proper treatment. (DBSA, 1996)
- An estimated 50% of unsuccessful treatment for depression is due to medical non-compliance. Patients stop taking their medication too soon due to unacceptable side effects, financial factors, fears of addiction and/or short-term improvement of symptoms, leading them to believe that continuing treatment is unnecessary. (DBSA, 1999)
- Participation in a DBSA patient-to-patient support group improved treatment compliance by almost 86% and reduced in-patient hospitalization. Support group participants are 86% more willing to take medication and cope with side effects. (DBSA, 1999)

*NOTE: The above information, beginning with Who Is Affected by Depression is taken from the DBSA website. The references used by DBSA are cited at the end of each bulleted statement.

S.C.R.E.A.M.
A New Way To View and Understand Depression

Thought up by
*Dr. Karen McCleskey

(*who makes no guarantees about the validity or reliability of this model)

This is simply an additional way to think about the components that potentially affect depression and used appropriately, may help with the some of the issues surrounding it.

S suppression

C connection

R rejection or repression or regression

E education

A affection

M meditation and/or medication

In conclusion, while depression is not curable at this time, there are many, many treatments, both old and new, that help one through it. The only thing worse than depression is untreated depression. The treatments are here. It is the job of clinicians to work with the client in determining the best one.

References:

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