



*Mental Health
Wellness Series:*
DEPRESSION

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Lunch and Learn Lecture Series

Overview

- Facts – What is Depression?
 - Co-morbidity with other disorders
- How Depression is Diagnosed
 - The Diagnostic Manual of Mental Disorders IV – Revised (DSM-IV-TR)
- Symptoms & Types
- Causes
- Tests, Treatment & Care
- Are you at Risk?
- Home Remedies
- Suicide/Finding Help

Facts about Depression

- It is estimated that by the year 2020, major depression will be one of the top two leading causes of illness in the world...2nd only to heart disease.
- 14.8 million adults in the U.S. suffer from major depression, according to the National Institute of Mental Health.
- As many as one in 33 children and one in 8 adolescents may experience major depression.
- The suicide rate for individuals with major depression is higher than any other psychiatric condition (including schizophrenia).
- Suicide is the 3rd leading cause of death in individuals ages 10-24.
- Most individuals with clinical depression *never* seek treatment.
- Depression commonly occurs with other mental disorders such as anxiety, eating disorders, panic disorders, phobias, and obsessive compulsive disorders.
- There are 10 or more known types of depression.

How Depression is Diagnosed

Many people are unaware that a diagnosis of *depression* actually begins with the diagnosis of a **single major depressive episode**. The diagnosis is then further specified according to the presence and pattern of various additional criteria sets.

According to the DSM-IV-TR, the criteria for a single depressive episode is the following:

- A. Five (or more) of the following symptoms that are present during the same 2-week period, with at least one symptom being 1) depressed mood or 2) anhedonia.
- 1) Depressed mood most of the day every day (in children & adolescents, may be irritable mood)
 - 2) Markedly diminished interest or pleasure in all, or almost all, activities (anhedonia)
 - 3) Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day
 - 4) Insomnia or hypersomnia nearly every day
 - 5) Psychomotor agitation or retardation every day
 - 6) Fatigue or loss of energy nearly every day
 - 7) Feelings of worthlessness or excessive or inappropriate guilt
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day
 - 9) Recurrent thoughts of death (not just a fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Symptoms

In addition to the criteria sets described by the DSM-IV-TR, the National Institute of Mental Health (NIMH) has also listed the following symptoms:

- Difficulty concentrating, remembering details, and making decisions
- Fatigue and decreased energy
- Feelings of guilt, worthlessness, and/or helplessness
- Feelings of hopelessness and/or pessimism
- Insomnia, early-morning wakefulness, or excessive sleeping
- Irritability or restlessness
- Loss of interest in activities that used to be pleasurable, including sex
- Overeating or appetite loss
- Persistent aches/pains, cramps, or digestive problems that do not ease with treatment
- Persistent sad, anxious, or “empty” feelings
- Thoughts of suicide or suicide attempts

Types

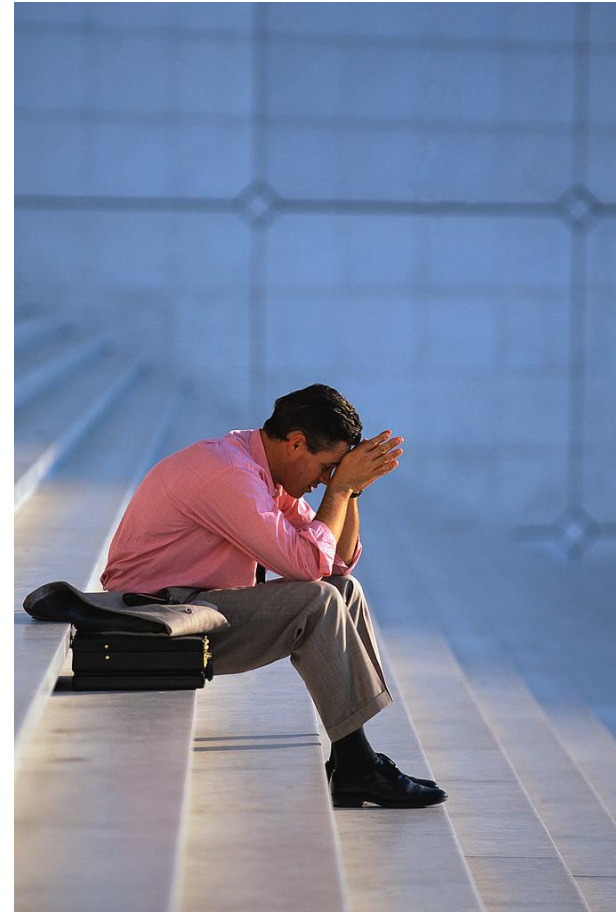
- Major Depressive Disorder, Single Episode
 - Presence of a single Major Depressive Episode
- Major Depressive Disorder, Recurrent
 - Presence of two or more Major Depressive Episodes (there must be an interval of at least 2 months)
- Dysthymic Disorder
 - Depressed mood for most of the day, for more days than not, for at least 2 years, but not meeting criteria for a Major Depressive Episode (in children and teens the mood may be irritable for at least 1 year)
- Major Depressive Disorder, Not Otherwise Specified

Specifiers

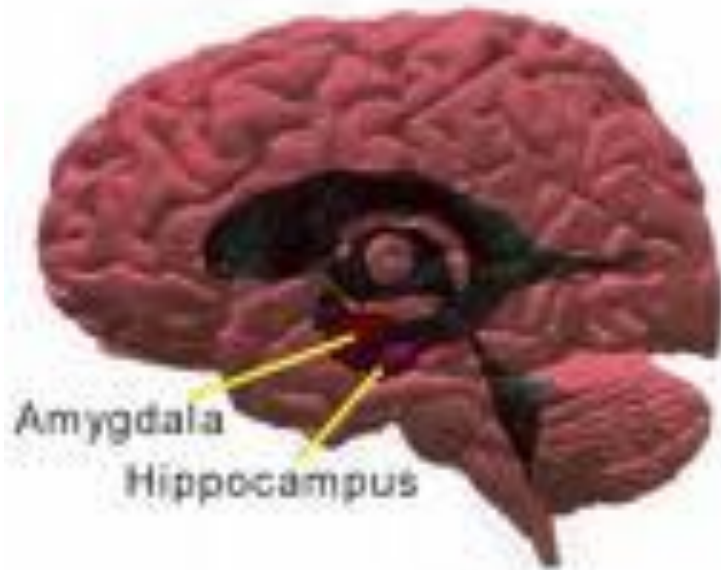
- “Specifiers” act as a classification for the *current* status and/or features of an individual’s diagnosis.
 - Mild, Moderate, Severe with or without Psychotic Features
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset
 - In Partial or Full Remission
 - With Seasonal Pattern
 - Longitudinal Course Specifiers (with or without inter-episode recovery)

Causes

- **Abuse** – physical, emotional, sexual
- **Medications** – beta-blockers (high blood pressure medication), barbiturates, benzodizapendines
- **Conflict** – friends, family, co-workers
- **Death or loss**
- **Genetics** – a family history of depression significantly increases your risk
- **Major events** – even positive events such as a new job, graduation, or getting married can trigger depression
- **Other personal problems** – social isolation
- **Serious illnesses**
- **Substance abuse** – nearly 30% of individuals with substance abuse problems also suffer from depression



The Biological Link



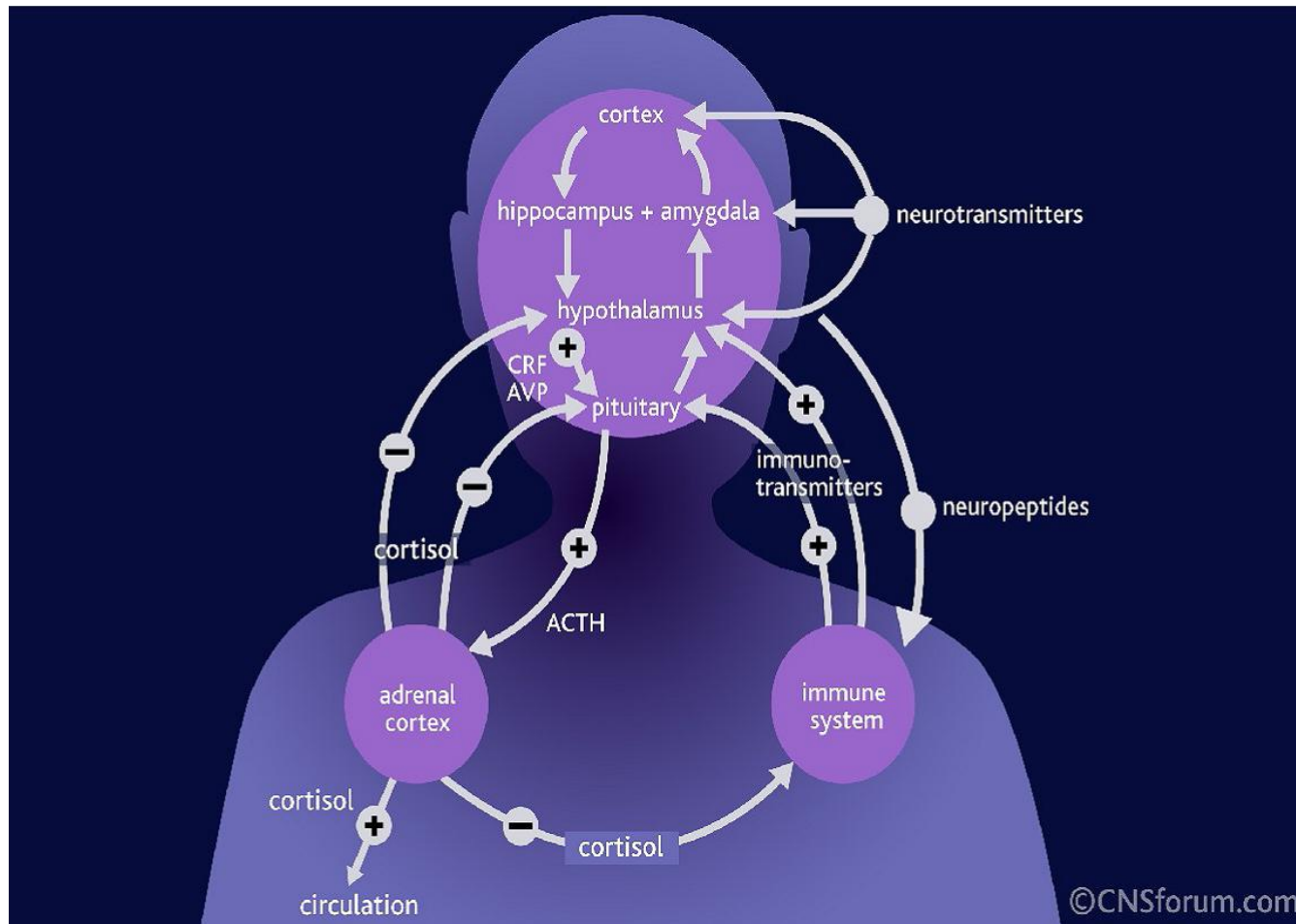
There is a reason why pharmaceutical medication is the most common form of treatment for depression: there *are* differences between the brains of some depressed individuals.

- The hippocampus (a vital area of the brain responsible for storing memories and associated emotions) has been shown to be smaller in depressed individuals.
- A smaller hippocampus has fewer serotonin receptors. Serotonin is produced by the body, but if the body is unable to receive these chemicals then depression may be experienced.

The Biological Link (cont'd): The HPA-Axis & Cortisol

- Hypothalamus – responsible for regulating the following functions:
 - Salt cravings
 - Feeding regulations (hunger and thirst)
 - Temperature regulation
 - Water retention
 - Metabolism levels
 - Thirst
 - Heart rate
 - Mood and behavioral functions
 - Sleep cycles

The Biological Link (cont'd): The HPA Axis & Cortisol



Tests

- There are a variety of depression “tests” your doctor might use to assess your symptoms. Keep in mind that these “tests” might not be tests at all, but used to rule out (R/O) major medical illnesses.
 - Physical exam and lab tests (R/O thyroid conditions, cancer, neuronal/hormonal conditions, etc.)
 - Central nervous system tumors
 - Head trauma
 - Multiple Sclerosis
 - Stroke
 - Blood tests (anemia, thyroid/hormone levels, calcium levels, electrolytes, kidney and liver function)
 - Depression Screening Inventory (e.g. the Beck Depression Scale)



Treatment

- Medicinal treatment is not the only method used to treat depression.
- Discuss the various treatment methods with your doctor to determine the best for you.
 - Pharmaceutical treatment (anti-depressants)
 - Psychotherapy or counseling
 - Electroconvulsive Therapy (ECT)
 - Transcranial Magnetic Stimulation (TMS)

Antidepressants

- Tricyclic Antidepressants (TAs)
 - First generation of drugs to treat depression
 - Operate on the serotonin and norepinephrine brain chemicals
 - Significant side effects; typically not the first choice of drug treatment
- Monoamine Oxidase Inhibitors (MAOIs)
 - Most effective for individuals who do not respond to other treatments
 - Dangerous interactions with certain foods, so individuals on this type of medication must adhere to dietary restrictions
- Selective Serotonin Reuptake Inhibitors (SSRIs)
 - Newer drugs that focus on specific types of serotonin
 - Alter the amount of serotonin available in the brain
- Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)
 - Another new type of antidepressant that increases the availability of both serotonin and norepinephrine in the brain

Antidepressants

- Antidepressant medication can take as long as 2 or 3 weeks to reach full potency!
- Medication must be taken on a regular schedule to have the highest degree of effectiveness.
- Keep records of your emotions (e.g. how intense your depression is) so you can work with your doctor to adjust the dosage.

Psychotherapy

- Ask your doctor for referrals to local counselors or therapists.
- Research has shown that depression is often best relieved with multiple modes of treatment, such as psychotherapy combined with drug therapy.
- Let go of the “lay-on-the-couch-tell-me-how-you-feel” concept of therapy!



Who should I see?

Primary Care Physician

- Medical Degree
- Can specialize in any field
- Typically serves only 1 6-week rotation in a psychiatric setting
- Prescription privileges
- Typically covered by most health insurance plans

Psychiatrist

- Medical Degree
- Specializes in the treatment of mental disorders
- Prescription privileges
- May or may not be covered by health insurance plans

Psychologist

- Research (Ph.D.) or clinical (Psy.D.) degree, usually specializing in a specific field
- Specializes in various modes of therapy
- NO prescription privileges
- Typically not covered by health insurance plans

ECT and TMS

- Electroconvulsive therapy (also known as electroshock therapy) is usually used to treat chronic depression.
 - A doctor applies a brief electric current through the scalp into the brain where the current induces a very brief seizure.
 - This is a highly effective mode of treatment.
- The FDA has recently cleared Transcranial Magnetic Stimulation for treating depressed adults who do not response to antidepressant medication.
 - Where ECT uses an electric current to induce a small seizure, TMS creates a magnetic field that induces a much smaller current to a very specific portion of the brain. There is no seizure and no loss of consciousness.
 - This treatment can be conducted on an outpatient basis.

Home Remedies

- In some cases, mild cases of depression can be eased with home remedies or alternative therapies.
 - **Alternative therapies include:**
 - Acupuncture
 - Aromatherapy
 - Biofeedback
 - Chiropractic treatment
 - Hypnosis
 - Massage therapy
 - Yoga/Meditation**
 - Herbal remedies (St. John's Wort)
 - **Exercise**
 - **Diet**

Suicide Facts

- Suicide is the 3rd leading cause of death for individuals 10-24 years old and the 2nd leading cause for individuals 25-34 years old.
- Suicide rates have increased for individuals 65 years old and older (1 suicide death for every 4 suicide attempts).
- A gun is the most common method of suicide.
- Women *attempt* suicide more often than men, but men are twice more likely to succeed.
- Most people who seriously consider suicide **do not** want to die; rather, they see death as a solution to their problem or pain.
- **THERE IS NO RESEARCH THAT SUPPORTS THE MYTH THAT TALKING ABOUT SUICIDE LEADS TO SUICIDAL THOUGHTS OR SUICIDE!**

Warning Signs of Suicide

- A sudden switch from being very sad to being very calm or appearing to be happy.
- Persistent talk or thoughts about death and dying.
- Worsening clinical depression.
- Taking unnecessary and increasingly dangerous risks that could result in death (having a “death” wish or “tempting fate”).
- Anhedonia (loss of interest in activities/hobbies).
- Making comments about being worthless, hopeless, and/or unloved.
- “Putting affairs in order,” such as updating a will.
- Talking about suicide, such as various methods or plans for killing oneself.
- Visiting/calling people one cares about.
- “It would be better if I were dead.”

Suicidal Helplines

All threats of suicide should be taken **very** seriously. An individual is believed to be at the highest risk for committing suicide when:

- The individual has possession of the means to commit suicide (e.g. a gun, medication, alcohol, other weapons).
 - The individual has a set time and place to commit suicide.
 - The individual believes there is no other way to end the pain or solve the problem.
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- 1.800.SUICIDE (1.800.784.2433)
 - 1.800.273.TALK (1.800.273.8255)
 - Deaf Hotline: 1.800.4889

Suicidal Friends/Loved Ones

What do I do if a friend or loved one appears suicidal?

1. If the suicide threat seems real and the person has a specific plan:
 1. Call 9-1-1 or the police in order to prevent the person from carrying out the act.
2. Consider your own safety first!
 1. If the environment is SAFE (and ONLY if it is safe), stay with the person or have a person you trust stay with the person, until help arrives.
 2. Do NOT argue with the person (“It’s not as bad as you think”) or challenge the person (“You’re not the type of person to commit suicide”).
 3. Talk about the situation as openly as possible. Be compassionate.
3. If you think someone you know has a suicide plan, call a health professional such as a doctor or counselor.
4. If you can not contact a doctor or counselor, contact a suicidal help hotline (see previous slides).

Questions? Comments?

Please email Shannon at
Shendrix-Buxton@nifs.org

if you have further questions or concerns
regarding this presentation on depression.

Next Week's Teleconference:

ANXIETY

September 10, 12pm/3pm EST