



## **MOOD DISORDERS ASSOCIATION OF MANITOBA INC.**

PROVINCIAL OFFICE: 100-4 FORT STREET WINNIPEG MANITOBA R3C 1C4  
PHONE: (204) 786-0987 TOLL FREE (OUTSIDE OF WINNIPEG) 1 (800) 263-1460 FAX: (204) 775-3497  
WEB: depression.mb.ca E-MAIL: sdmdm@depression.mb.ca

### **DEPRESSION**

#### **What Every Woman Should Know**

Sources: National Institute of Mental Health (NIMH),  
National Alliance for the Mentally Ill (NAMI),  
The Cleveland Clinic

Life is full of emotional ups and downs. But when the 'down' times are long lasting or interfere with your ability to function, you may be suffering from a common, serious illness-depression. Clinical depression affects mood, mind, body, and behavior. Research has shown that in the United States, about 19 million people - one in ten adults - experience depression each year, and nearly two-thirds do not get the help they need. Treatment can alleviate the symptoms in over 80 percent of the cases. Yet, because it often goes unrecognized, depression continues to cause unnecessary suffering.

Depression is a pervasive and impairing illness that affects both women and men, but women experience depression at roughly twice the rate of men. Researchers continue to explore how special issues unique to women-biological, life cycle, and psycho-social-may be associated with a women's higher rate of depression.

No two people become depressed in exactly the same way. Many people have only some of the symptoms, varying in severity and duration. For some, symptoms occur in time-limited episodes; for others, symptoms can be present for long periods if no treatment is sought. Having some depressive symptoms does not mean a person is clinically depressed. For example, it is not unusual for those who have lost a loved one to feel sad, helpless, and disinterested in regular activities. Only when these symptoms persist for an unusually long time is there reason to suspect that grief has become depressive illness. Similarly, living with the stress of potential layoffs, heavy workloads, or financial or family problems may cause irritability and "the blues." Up to a point, such feelings are simply a part of human experience. But when these feelings increase in duration and intensity and an individual is unable to function as usual, what seemed a temporary mood may have become a clinical illness.

#### **Types of depressive illness**

- 1.) In *major depression*, sometimes referred to as unipolar or clinical depression, people have some or all of the symptoms listed below for at least 2 weeks but

frequently for several months or longer. Episodes of the illness can occur once, twice, or several times in a lifetime.

- 2.) In *dysthymia*, the same symptoms are present though milder and last at least 2 years. People with dysthymia are frequently lacking in zest and enthusiasm for life, living a joyless and fatigued existence that seems almost a natural outgrowth of their personalities. They also can experience major depressive episodes.
- 3.) *Manic-depression*, or bipolar disorder, is not nearly as common as other forms of depressive illness and involves disruptive cycles of depressive symptoms that alternate with mania. During manic episodes, people may become overly active, talkative, euphoric, irritable, spend money irresponsibly, and get involved in sexual misadventures. In some people, a milder form of mania, called hypomania, alternates with depressive episodes. Unlike other mood disorders, women and men are equally vulnerable to bipolar disorder; however, women with bipolar disorder tend to have more episodes of depression and fewer episodes of mania or hypomania.

## **Symptoms of depression and mania**

A thorough diagnostic evaluation is needed if three to five or more of the following symptoms persist for more than 2 weeks (1 week in the case of mania), or if they interfere with work or family life. An evaluation involves a complete physical checkup and information gathering on family health history. Not everyone with depression experiences each of these symptoms. The severity of the symptoms also varies from person to person.

### **Depression**

- Persistent sad, anxious, or ‘empty’ mood
- Loss of interest or pleasure in activities, including sex
- Restlessness, irritability, or excessive crying
- Feelings of guilt, worthlessness, helplessness, pessimism
- Sleeping too much or too little, early-morning awakening
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, feeling ‘slowed down’
- Thoughts of death or suicide, or suicide attempts
- Difficulty concentrating, remembering, or making decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

### **Mania**

- Abnormal elevated mood
- Irritability
- Decreased need for sleep
- Grandiose notions

- Increased talking
- Racing thoughts
- Increased activity, including sexual activity
- Markedly increased energy
- Poor judgment that leads to risk-taking behavior
- Inappropriate social behavior

## **Causes of depression**

### ➤ **Genetic Factors**

There is a risk for developing depression when there is a family history of the illness, indicating that a biological vulnerability may be inherited. The risk is somewhat higher for those with bipolar disorder. However, not everybody with a family history develops the illness. In addition, major depression can occur in people who have had no family members with the illness. This suggests that additional factors, possibly biochemistry, environmental stressors, and other psychosocial factors, are involved in the onset of depression.

### ➤ **Biochemical Factors**

Evidence indicates that brain biochemistry is a significant factor in depressive disorders. It is known, for example, that individuals with major depressive illness typically have dysregulation of certain brain chemicals, called neurotransmitters. Additionally, sleep patterns, which are biochemical-influenced, are typically different in people with depressive disorders. Depression can be induced or alleviated with certain medications, and some hormones have mood-altering properties. What is not yet known is whether the "biochemical disturbances" of depression are of genetic origin, or are secondary to stress, trauma, physical illness, or some other environmental condition.

### ➤ **Environmental and Other Stressors**

Significant loss, a difficult relationship, financial problems, or a major change in life pattern have all been cited as contributors to depressive illness. Sometimes the onset of depression is associated with acute or chronic physical illness. In addition, some form of substance abuse disorder occurs in about one-third of people with any type of depressive disorder.

### ➤ **Other Psychological and Social Factors**

Persons with certain characteristics-pessimistic thinking, low self-esteem, a sense of having little control over life events, and a tendency to worry excessively-are more likely to develop depression. These attributes may heighten the effect of stressful events or interfere with taking action to cope with them or with getting well. Upbringing or sex role expectations may contribute to the development of these traits. It appears that negative thinking patterns typically develop in childhood or adolescence. Some experts have suggested that the traditional upbringing of girls might foster these traits and may be a factor in women's higher rate of depression.

## **Why is depression more common in women?**

Rates of depression are similar in girls and boys before adolescence, but with the onset of puberty, a female's risk of developing depression increases dramatically, to twice that of males. Experts believe that women may be more prone to depression because of changes in hormone levels that occur throughout a woman's life such as during puberty, pregnancy, and menopause, as well as after giving birth, having a hysterectomy, or experiencing a miscarriage. In addition, the hormone fluctuations that occur with each month's menstrual cycle increase the risk for premenstrual syndrome, or PMS, and premenstrual dysphoric disorder, or PMDD.

According to the National Institutes of Health, several other factors that are unique to women may contribute to their higher rates of depression. These include reproductive, genetic, or other biological factors, interpersonal factors, and certain psychological and personality characteristics.

In addition, for women trying to balance a home and a career, stresses continue to pile up.

## **The many dimensions of depression in women**

Investigators are focusing on the following areas in their study of depression in women:

### ➤ **The Issues of Adolescence**

Before adolescence, there is little difference in the rate of depression in boys and girls. But between the ages of 11 and 13 there is a precipitous rise in depression rates for girls. By the age of 15, females are twice as likely to have experienced a major depressive episode as males. This comes at a time in adolescence when roles and expectations change dramatically. The stresses of adolescence include forming an identity, emerging sexuality, separating from parents, and making decisions for the first time, along with other physical, intellectual, and hormonal changes. These stresses are generally different for boys and girls, and may be associated more often with depression in females. Studies show that female high school students have significantly higher rates of depression, anxiety disorders, eating disorders, and adjustment disorders than male students, who have higher rates of disruptive behavior disorders.

### ➤ **Adulthood: Relationships and Work Roles**

Stress in general can contribute to depression in persons biologically vulnerable to the illness. Some have theorized that higher incidence of depression in women is not due to greater vulnerability, but to the particular stresses that many women face. These stresses include major responsibilities at home and work, single parenthood, and caring for children and aging parents. How these factors may uniquely affect women is not yet fully understood.

For both women and men, rates of major depression are highest among the separated and divorced, and lowest among the married, while remaining always higher for women than for men. The quality of marriage, however, may contribute significantly to depression. Lack of an intimate, confiding relationship, as well as marital disputes, have shown to be

related to depression in women. In fact, rates of depression were shown to be highest among unhappily married women.

➤ **Specific Cultural Considerations**

As for depression in general, the prevalence rate of depression in African American and Hispanic women remains about twice that of men. There is some indication, however, that major depression and dysthymia may be diagnosed less frequently in African American and slightly more frequently in Hispanic than in Caucasian women. Prevalence information for other racial and ethnic groups is not definitive.

Possible differences in symptom presentation may affect the way depression is recognized and diagnosed among minorities. For example, African Americans are more likely to report somatic symptoms, such as appetite change and body aches and pains. In addition, people from various cultural backgrounds may view depressive symptoms in different ways. Such factors should be considered when working with women from special populations.

➤ **Victimization**

Studies show that women molested as children are more likely to have clinical depression at some time in their lives than those with no such history. In addition, several studies show a higher incidence of depression among women who have been raped as adolescents or adults. Since far more women than men were sexually abused as children, these findings are relevant. Women who experience other commonly occurring forms of abuse, such as physical abuse and sexual harassment on the job, also may experience higher rates of depression. Abuse may lead to depression by fostering low self-esteem, a sense of helplessness, self-blame, and social isolation. There may be biological and environmental risk factors for depression resulting from growing up in a dysfunctional family. At present, more research is needed to understand whether victimization is connected specifically to depression.

➤ **Poverty**

Women and children represent seventy-five percent of the U.S. population considered poor. Low economic status brings with it many stresses, including isolation, uncertainty, frequent negative events, and poor access to helpful resources. Sadness and low morale are more common among persons with low incomes and those lacking social supports. But research has not yet established whether depressive illnesses are more prevalent among those facing environmental stressors such as these.

➤ **Depression in Later Adulthood**

At one time, it was commonly thought that women were particularly vulnerable to depression when their children left home and they were confronted with 'empty nest syndrome' and experienced a profound loss of purpose and identity. However, studies show no increase in depressive illness among women at this stage of life.

As with younger age groups, more elderly women than men suffer from depressive illness. Similarly, for all age groups, being unmarried (which includes widowhood) is also a risk factor for depression. Most important, depression should not be dismissed as a normal consequence of the physical, social, and economic problems of later life. In fact, studies show that the majority of older people feel satisfied with their lives.

About 800,000 persons are widowed each year. Most of them are older, female, and experience varying degrees of depressive symptomatology. Most do not need formal treatment, but those who are moderately or severely sad appear to benefit from self-help groups or various psychosocial treatments. However, a third of widows/widowers do meet criteria for major depressive episode in the first month after the death, and half of these remain clinically depressed 1 year later. These depressions respond to standard antidepressant treatments, although research on when to start treatment or how medications should be combined with psychosocial treatments is still in its early stages.

➤ **Reproductive events**

Women's reproductive events include the menstrual cycle, pregnancy, the post-pregnancy period, infertility, menopause, and sometimes, the decision not to have children. These events bring fluctuations in mood that for some women include depression. Researchers have confirmed that hormones have an effect on the brain chemistry that controls emotions and mood; a specific biological mechanism explaining hormonal involvement is not known, however.

## **The Phases In A Woman's Life**

➤ **Premenstrual Syndrome (PMS) and  
Premenstrual Dysphoric Disorder (PMDD)**

Up to 75% of menstruating women experience premenstrual syndrome (PMS), a disorder characterized by emotional and physical symptoms that fluctuate in intensity from one menstrual cycle to the next, usually affecting women in their 20s or 30s.

Some 3-5% of menstruating women experience premenstrual dysphoric disorder, or PMDD, a severe form of PMS, marked by highly emotional and physical symptoms that usually become more severe 7 to 10 days before the onset of menstruation.

In the last decade, these fluctuations in hormone levels have become recognized as important causes of discomfort and behavioral change in women. While the precise link between PMS, PMDD, and depression is still unknown, chemical changes in the brain and fluctuating hormone levels are both thought to be contributing factors.

### **Treating PMS and PMDD**

Many women find improvement by exercising, taking vitamins, and avoiding caffeine. For individuals with severe symptoms, medicine, individual and group psychotherapy, stress management, or marital therapy can be helpful.

### ➤ **Pregnancy and depression**

Pregnancy has long been viewed as a period of wellbeing that protected against psychiatric disorders. But depression occurs almost as commonly in pregnant women as it does in non-pregnant women.

#### **What factors increase the risk of being depressed in pregnancy?**

- Having a history of depression or PMDD
- Age at time of pregnancy -- the younger you are, the higher the risk
- Living alone
- Limited social support
- Children -- the more you have, the more likely you are to be depressed during a later pregnancy
- Marital conflict
- Uncertainty about the pregnancy

#### **What is the impact of depression on pregnancy?**

Depression can interfere with a woman's ability to care of herself during pregnancy. She may be less able to follow medical recommendations, and sleep and eat properly. Depression can cause a woman to use substances such as tobacco, alcohol, and/or illegal drugs, which could harm the baby. Depression can make bonding with the baby difficult.

#### **How does pregnancy impact depression?**

The stresses of pregnancy can cause depression or a recurrence or worsening of depression symptoms. Depression during pregnancy can increase the risk for having depression after delivery (postpartum depression, see below).

#### **What are the options if depression occurs during pregnancy?**

Preparing for a new baby is lots of hard work, but your health should come first. Resist the urge to get everything done, cut down on your chores, and do those things that will help you to relax. In addition, talking about things that concern you is very important. Talk to your friends, your partner, and your family. If you ask for support, you will find you often get it.

If all else fails, and you're still down and anxious, consider seeking therapy. Ask your doctor or midwife for a referral to a mental healthcare professional.

#### **Treating depression during pregnancy**

Growing evidence suggests that many of the currently available antidepressant medicines are safe for treating depression during pregnancy, at least in terms of short-term effects on the baby. Long-term effects have not been properly studied. You should discuss the possible risks and benefits with your doctor.

### ➤ **Postpartum Depression**

Depression following childbirth is a complex mix of physical, emotional, and behavioral changes that are attributed to the chemical, social, and psychological changes associated with having a baby.

#### **What factors increase the risk of being depressed after the birth of a child?**

- Having a personal or family history of depression or PMDD
- Age at time of pregnancy -- the younger you are, the higher the risk
- Living alone
- Limited social support
- Children -- the more you have, the more likely you are to be depressed in a later pregnancy
- Marital conflict
- Uncertainty about the pregnancy
- A history of depression during pregnancy -- 50% of depressed pregnant women will have postpartum depression

#### **Types of postpartum depression (PPD)**

***Postpartum blues*** -- Better known as the 'baby blues', this condition affects between 50-75% of women after delivery. If you are experiencing the baby blues, you will have frequent, prolonged bouts of crying for no apparent reason, sadness, and anxiety. The condition usually begins in the first week (one to four days) after delivery. Although the experience is unpleasant, the condition usually subsides within two weeks without treatment. All you'll need is reassurance and help with the baby and household chores.

***Postpartum depression*** -- This is a far more serious condition than postpartum blues, affecting about one in 10 new mothers. You may experience alternating 'highs' and 'lows', frequent crying, irritability, and fatigue, as well as feelings of guilt, anxiety, and an inability to care for your baby or yourself. Symptoms range from mild to severe and may appear within days of the delivery or gradually, even up to a year later. Although symptoms can last from several weeks up to a year, treatment with psychotherapy or antidepressants is very effective.

***Postpartum psychosis*** -- This is an extremely severe form of postpartum depression and requires emergency medical attention. This condition is relatively rare, affecting only one in 1,000 women after delivery. The symptoms generally occur quickly after delivery and are severe, lasting for a few weeks to several months. Symptoms include severe agitation, confusion, feelings of hopelessness and shame, insomnia, paranoia, delusions or hallucinations, hyperactivity, rapid speech, or mania.

Postpartum psychosis requires immediate medical attention since there is an increased risk of suicide and risk of harm to the baby. Treatment will usually include admission to hospital for the mother, and medicine.

### **What causes postpartum depression?**

More research is needed to determine the link between the rapid drop in hormones after delivery and depression. The levels of estrogen and progesterone, the female reproductive hormones, increase tenfold during pregnancy but drop sharply after delivery. By three days following delivery, levels of these hormones drop back to pre-pregnant levels. In addition to these chemical changes, the social and psychological changes associated with having a baby create an increased risk of postpartum depression.

### **Can postpartum depression be prevented?**

Here are some tips that can help prevent, or help you cope with postpartum depression:

- Be realistic about your expectations for yourself and your baby
- Limit visitors when you first go home
- Ask for help -- let others know how they can help you
- Sleep or rest when your baby sleeps
- Exercise; take a walk and get out of the house for a break
- Screen your phone calls
- Follow a sensible diet; avoid alcohol and caffeine
- Keep in touch with your family and friends -- do not isolate yourself
- Foster your relationship with your partner -- make time for each other
- Expect some good days and some bad days

### **Treating postpartum depression**

Postpartum depression is treated differently depending on the type and severity of the woman's symptoms. Treatment options include anti-anxiety or antidepressant medicines, psychotherapy, and support group participation.

In the case of postpartum psychosis, medicines used to treat psychosis are usually added. Hospital admission is also usually necessary.

If you are breastfeeding, don't assume that you can't take medicines for depression, anxiety, or even psychosis. There have been no reports of breastfed babies whose mothers are taking antidepressants suffering any ill effects, but as yet no long-term results are available.

### **When should a new mother seek professional medical treatment?**

- Symptoms persist beyond two weeks
- She is unable to function normally; she can't cope with everyday situations
- She has thoughts of harming herself or her baby
- She is feeling extremely anxious, scared, and panicked most of the day

### ➤ **Perimenopause and Menopause**

Perimenopause is the stage of a woman's reproductive life that begins 8 to 10 years before menopause, when the ovaries gradually begin to produce less estrogen. Perimenopause lasts up until menopause, the point when the ovaries stop releasing eggs. In the last one to two years of perimenopause, the decrease in estrogen accelerates. At this stage, many women experience menopausal symptoms.

### **What is menopause?**

Menopause is period of time when a woman stops having her monthly period and experiences symptoms related to the lack of estrogen production. By definition, a woman is in menopause after her periods have stopped for one year. It is a normal part of aging and marks the end of a woman's reproductive years. Menopause typically occurs in a woman's late 40s to early 50s. However, women who have their ovaries surgically removed undergo 'sudden' menopause.

The drop in estrogen levels during perimenopause and menopause triggers physical as well as emotional changes -- such as depression or anxiety, and changes in memory. Some physical changes include irregular or skipped periods, heavier or lighter periods, and hot flashes. Like any other point in a woman's life, there is a relationship between hormone levels and physical and emotional symptoms.

### **Coping with the symptoms of menopause**

There are many ways you can ease menopause symptoms and maintain your health. These tips include ways to cope with mood swings, fears and depression:

- Find a self-calming skill to practice such as yoga, meditation, or slow, deep breathing.
- Avoid tranquilizers.
- Engage in a creative outlet or hobby that fosters a sense of achievement.
- Stay connected with your family and community; nurture your friendships.
- Seek emotional support from friends, family members, or a professional counselor when needed.
- Take steps to stay cool during hot flashes, such as wearing loose clothing.
- Keep your bedroom cool to prevent night sweats and disturbed sleep.
- Take medicines, vitamins, and minerals as prescribed by your doctor.
- Eat healthfully and exercise regularly.

### **Depression is a treatable illness**

Even severe depression can be highly responsive to treatment. Indeed, believing one's condition is "incurable" is often part of the hopelessness that accompanies serious depression. Such individuals should be provided with the information about the effectiveness of modern treatments for depression in a way that acknowledges their likely

skepticism about whether treatment will work for them. As with many illnesses, the earlier treatment begins, the greater the likelihood of preventing serious recurrences. Of course, treatment will not eliminate life's inevitable stresses and ups and downs. But it can greatly enhance the ability to manage such challenges and lead to greater enjoyment of life.

The first step in treatment for depression should be a thorough examination to rule out any physical illnesses that may cause depressive symptoms. Since certain medications can cause the same symptoms as depression, the examining physician should be made aware of any medications being used. If a physical cause for the depression is not found, a psychological evaluation should be conducted by the physician or a referral made to a mental health professional.

### **Types of treatment for depression**

The most commonly used treatments for depression are antidepressant medication, psychotherapy, or a combination of the two. Which of these is the right treatment for any one individual depends on the nature and severity of the depression and, to some extent, on individual preference. In mild or moderate depression, one or both of these treatments may be useful, while in severe or incapacitating depression, medication is generally recommended as a first step in the treatment. In combined treatment, medication can relieve physical symptoms quickly, while psychotherapy allows the opportunity to learn more effective ways of handling problems.

#### **➤ Medications**

There are several types of antidepressant medications used to treat depressive disorders. These include newer medications—chiefly the selective serotonin reuptake inhibitors (SSRIs)—and the tricyclics and monoamine oxidase inhibitors (MAOIs). The SSRIs—and other newer medications that affect neurotransmitters such as dopamine or norepinephrine—generally have fewer side effects than tricyclics. Each acts on different chemical pathways of the human brain related to moods. Antidepressant medications are not habit-forming. Although some individuals notice improvement in the first couple of weeks, usually antidepressant medications must be taken regularly for at least 4 weeks and, in some cases, as many as 8 weeks, before the full therapeutic effect occurs. To be effective and to prevent a relapse of the depression, medications must be taken for about 6 to 12 months, carefully following the doctor's instructions. Medications must be monitored to ensure the most effective dosage and to minimize side effects. For those who have had several bouts of depression, long-term treatment with medication is the most effective means of preventing recurring episodes.

The prescribing doctor will provide information about possible side effects and, in the case of MAOIs, dietary and medication restrictions. In addition, other prescribed and over-the-counter medications or dietary supplements being used should be reviewed because some can interact negatively with antidepressant medication. There may be restrictions during pregnancy.

For bipolar disorder, the treatment of choice for many years has been lithium, as it can be effective in smoothing out the mood swings common to this disorder. Its use must be carefully monitored, as the range between an effective dose and a toxic one can be relatively small. However, lithium may not be recommended if a person has pre-existing thyroid, kidney, or heart disorders or epilepsy. Fortunately, other medications have been found helpful in controlling mood swings. Among these are two mood-stabilizing anticonvulsants, carbamazepine (Tegretol) and valproate (Depakote). Both of these medications have gained wide acceptance in clinical practice; as a result, valproate has been approved by the Food and Drug Administration for first-line treatment of acute mania. Studies conducted in Finland in patients with epilepsy indicate that valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20; therefore, young female patients should be monitored carefully by a physician. Other anticonvulsants that are being used now include lamotrigine (Lamictal) and gabapentin (Neurontin); their role in the treatment hierarchy of bipolar disorder remains under study.

Most people who have bipolar disorder take more than one medication. Along with lithium and/or an anticonvulsant, they often take a medication for accompanying agitation, insomnia, or depression. Some research indicates that an antidepressant, when taken without a mood stabilizing medication, can increase the risk of switching into mania or hypomania, or of developing rapid cycling, in people with bipolar disorder. Finding the best possible combination of these medications is of utmost importance to the patient and requires close monitoring by the physician.

#### ➤ **Herbal Therapy**

In the past few years, much interest has risen in the use of herbs in the treatment of both depression and anxiety. **St. John's wort** (*Hypericum perforatum*), an herb used extensively in the treatment of mild to moderate depression in Europe, has recently aroused interest in the United States. St. John's wort, an attractive bushy, low-growing plant covered with yellow flowers in summer, has been used for centuries in many folk and herbal remedies. Today in Germany, *Hypericum* is used in the treatment of depression more than any other antidepressant. However, the scientific studies that have been conducted on its use have been short-term and have used several different doses.

Because of the widespread interest in St. John's wort, the National Institutes of Health (NIH) is conducting a 3-year study, sponsored by three NIH components - the National Institute of Mental Health, the National Institute for Complementary and Alternative Medicine, and the Office of Dietary Supplements. The study is designed to include 336 patients with major depression, randomly assigned to an 8-week trial with one-third of patients receiving a uniform dose of St. John's wort, another third an SSRI commonly prescribed for depression, and the final third a placebo (a pill that looks exactly like the SSRI and the St. John's wort, but has no active ingredients). The study participants who respond positively will be followed for an additional 18 weeks. After the 3-year study has been completed, results will be analyzed and published.

*The Food and Drug Administration issued a **Public Health Advisory** on February 10, 2000. It stated that St. John's wort appears to affect an important metabolic pathway that is used by many drugs prescribed to treat conditions such as heart disease, depression, seizures, certain cancers, and rejections of transplants. Therefore, health care providers should alert their patients about these potential drug interactions. Any herbal supplement should be taken only after consultation with the doctor or health care provider.*

➤ **Psychotherapy**

In mild to moderate cases of depression, psychotherapy is also a treatment option. Some short-term (10 to 20 week) therapies have been very effective in several types of depression. "Talking" therapies help patients gain insight into and resolve their problems through verbal give-and-take with the therapist. "Behavioral" therapies help patients learn new behaviors that lead to more satisfaction in life and "unlearn" counter-productive behaviors. Research has shown that two short-term psychotherapies, interpersonal and cognitive-behavioral, are helpful for some forms of depression. Interpersonal therapy works to change interpersonal relationships that cause or exacerbate depression. Cognitive-behavioral therapy helps change negative styles of thinking and behaving that may contribute to the depression.

➤ **Electroconvulsive Therapy**

For individuals whose depression is severe or life threatening or for those who cannot take antidepressant medication, electroconvulsive therapy (ECT) is useful. This is particularly true for those with extreme suicide risk, severe agitation, psychotic thinking, severe weight loss or physical debilitation as a result of physical illness. Over the years, ECT has been much improved. A muscle relaxant is given before treatment, which is done under brief anesthesia. Electrodes are placed at precise locations on the head to deliver electrical impulses. The stimulation causes a brief (about 30 seconds) seizure within the brain. The person receiving ECT does not consciously experience the electrical stimulus. At least several sessions of ECT, usually given at the rate of three per week, are required for full therapeutic benefit.

**Treating recurrent depression**

Even when treatment is successful, depression may recur. Studies indicate that certain treatment strategies are very useful in this instance. Continuation of antidepressant medication at the same dose that successfully treated the acute episode can often prevent recurrence. Monthly interpersonal psychotherapy can lengthen the time between episodes in patients not taking medication.

**The path to healing**

Reaping the benefits of treatment begins by recognizing the signs of depression. The next step is to be evaluated by a qualified professional. Although depression can be diagnosed and treated by primary care physicians, often the physician will refer the patient to a psychiatrist, psychologist, clinical social worker, or other mental health professional.

Treatment is a partnership between the patient and the health care provider. An informed consumer knows his or her treatment options and discusses with his or her provider as they arise.

If there are no positive results after 2 to 3 months of treatment, or if the symptoms worsen, discuss another treatment approach with the provider. Getting a second opinion from another health or mental health professional may also be in order.

Here, again, are the steps to healing:

- Check your symptoms against the list.
- Talk to a health or mental health professional.
- Choose a treatment professional and a treatment approach with which you feel comfortable.
- Consider yourself a partner in treatment and be an informed consumer.
- If you are not comfortable or satisfied after 2 to 3 months, discuss this with your provider.
- Different additional treatment may be recommended.
- If you experience a recurrence, remember what you know about coping with depression and don't shy away from help again. In fact, the sooner a recurrence is treated, the shorter its duration will be.

Depressive illnesses make you feel exhausted, worthless, helpless, and hopeless. Such feelings make some people want to give up. It is important to realize that these negative feelings are part of the depression and will fade as treatment begins to take effect.

Along with professional treatment, there are other things you can do to help yourself get better. Some people find participating in support groups very helpful. It may also help to spend some time with other people and to participate in activities that make you feel better, such as mild exercise or yoga. Just don't expect too much from yourself right away. Feeling better takes time.

## **Where to get help**

If unsure where to go for help, ask your family doctor, OB/GYN physician, or health clinic for assistance. In times of crisis, the emergency room doctor at a hospital may be able to provide temporary help for an emotional problem and will be able to tell you where and how to get further help. Listed here are the types of people and places that will make a referral to, or provide, diagnostic and treatment services.

- Family doctors
- Mental health specialists such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers

- Hospital psychiatry departments and outpatient clinics
- University - or medical school - affiliated programs
- Family service/social agencies
- Employee assistance programs
- Local medical and/or psychiatric societies

***“The single largest barrier is ignorance.”***