

WHAT IS MAJOR DEPRESSION?



BASIC FACTS • SYMPTOMS • TREATMENTS • FAMILIES



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basic facts

Major Depression is a medical condition distinguished by one or more Major Depressive Episodes. A Major Depressive Episode is characterized by at least two weeks of depressed mood or loss of interest (pleasure) and accompanied by at least four more symptoms of depression. Such symptoms can include changes in appetite, weight, difficulty in thinking and concentrating, and recurrent thoughts of death or suicide. Depression differs from feeling “blue” in that it causes severe enough problems to interfere with a person’s day-to-day functioning.

People’s experience with major depression varies. Some people describe it as a total loss of energy or enthusiasm to do anything. Others may describe it as constantly living with a feeling of impending doom.

Major depression is a medical condition where a person experiences an extremely low mood that interferes with day-to-day functioning.

Prevalence

Major depression is a common psychiatric disorder. It is more common in adolescent and adult women than in adolescent and adult men. Between fifteen and twenty out of every one hundred people (15-20 percent) experience an episode of major depression during their lifetime. Prevalence has not been found to be related to ethnicity, income, education, or marital status.

Between 15 to 20 people out of every 100 may experience major depression in their lifetime.

Diagnosis

Major depression cannot be diagnosed with a blood test, CAT-scan, or any other laboratory test. The only way to diagnose major depression is with a clinical interview. The interviewer checks to see if the person has experienced severe symptoms for at least two weeks. If the symptoms are less severe, but last over long periods of time, the person may be diagnosed with dysthymic disorder. The clinician must also check to be sure there are no physical problems that could cause symptoms like those of major depression, such as a brain tumor or a thyroid problem.

Major depression is an illness that must be determined by a diagnostic interview.

Course of Illness

The average age of onset is in the mid-20s, however, major depression can begin at any age in life. The frequency of episodes varies

from person to person. Some people have isolated episodes over many years, while others suffer from frequent episodes clustered together. The number of episodes generally increases as the person grows older. The severity of the initial episode of major depression seems to indicate persistence. Episodes also seem to follow major stressors, such as the death of a loved one or a divorce. Chronic medical conditions and substance abuse may further exacerbate depressive episodes.

Major depression may develop at any time. It can be a single episode or may reoccur over a person’s lifetime.

Causes

There is no simple answer to what causes depression because several factors play a part in the onset of the disorder. These include: a genetic or family history of depression, life events and environmental stressors, biological factors, and psychological vulnerability to depression.

Genetics research shows that the risk for depression results from the influence of multiple genes acting together with environmental factors. This is called the stress-vulnerability model. A family history of depression does not necessarily mean children or other relatives will develop major depression. However, those with a family history of depression have slightly higher chances of becoming depressed at some stage in their lives. Although genetic research suggests that depression can run in families, genetics alone are unlikely to cause depression. Environmental factors, such as a traumatic childhood or adult life events, may act as triggers. Studies show that early childhood trauma and losses, such as the death or separation of parents, or adult life events, such as the death of a loved one, divorce, the loss of a job, retirement, serious financial problems, and family conflict, can lead to the onset of depression. Subsequent episodes are usually caused by more mild stressors or even none at all.

Many scientists believe the cause is biological, such as an imbalance in brain chemicals, specifically serotonin and norepinephrine. There are also theories that physical changes to the body may play a role in depression. Such physical changes can include viral and other infections, heart attack, cancer, or hormonal disorders.

Personality style may also contribute to the onset of depression. People are at a greater risk of becoming depressed if they have low self-esteem, tend to worry a lot, are overly dependent on others, are perfectionists, or expect too much from themselves and others.

Scientists believe major depression is caused by several factors, including: a genetic or family history of depression, life events and environmental stressors, biological factors, and psychological vulnerability to depression.



symptoms of depression

A person who suffers from major depressive disorder must meet at least five symptoms of depression for at least a two week period. Social, occupational, and other areas of functioning must be significantly impaired, or at least require increased effort. Depressed mood caused by substances (such as drugs, alcohol, medications) or related to a general medical condition is not considered to be major depressive disorder. Major depressive disorder also cannot be diagnosed if a person has a history of manic, hypomanic, or mixed episodes (e.g., bipolar disorder) or if the depressed mood is better accounted for by schizoaffective disorder.

Not all symptoms must be present for a person to be diagnosed with depression. Five (or more) of the following symptoms have to be present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure.

1) Depressed mood most of the day, nearly everyday, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). In children and adolescents, this may be characterized as irritable mood rather than sad mood.

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. This includes activities that were previously found enjoyable.

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or a decrease or increase in appetite nearly every day.

4) Insomnia or hypersomnia nearly every day. The person may have difficulty falling asleep, staying asleep, or waking early in the morning and not being able to get back to sleep. Alternatively, the person may sleep excessively (such as over twelve hours per night) and spend much of the day in bed.

5) Psychomotor agitation (e.g., inability to sit still or pacing) or psychomotor retardation (e.g., slowed speech, thinking, and body movements) nearly every day. Changes in activity level are common in depression. The person may feel agitated, "on edge," and restless. Alternatively, they may experience decreased activity level reflected by slowness and lethargy, both in terms of the person's behavior and thought processes.

6) Fatigue or loss of energy nearly every day.

7) Feelings of worthlessness or excessive or inappropriate guilt nearly every day. Depressed people may feel they are worthless or that there is no hope for improving their lives. Feelings of guilt may be present about events that the person did not even do, such as a catastrophe, a crime, or an illness.

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day. Significant decreases in the ability to concentrate make it difficult to pay attention to others or contemplate simple tasks. The person may be quite indecisive about even minor things.

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

There are other psychiatric symptoms that depressed people often experience. They might complain of bodily aches and pains rather than feelings of sadness. They might report or exhibit persistent anger, angry outbursts, and an exaggerated sense of frustration over seemingly minor events. Symptoms of anxiety are also very common among people with depression. Other symptoms include hallucinations (false perceptions, such as hearing voices) and delusions (false beliefs, such as paranoid delusions). These symptoms usually disappear when the symptoms of depression have been controlled.

Common symptoms of depression include:

- Depressed mood
- Loss of interest/pleasure
- Change in appetite/weight
- Change in energy and activity level
- Feelings of worthlessness, hopelessness, and helplessness
- Guilt
- Recurrent thoughts of death



similar psychiatric disorders

Major depression shares symptoms with some of the other psychiatric disorders. If the person experiences very high or euphoric moods called mania, they would be given a diagnosis of bipolar disorder. If the person exhibits psychotic symptoms while not depressed, they might be diagnosed with schizoaffective disorder. Major depression must also be distin-

guished from Mood Disorder Due to a Medical condition. In this case, the mood disturbances are caused by physiological changes due to a medical condition.

The symptoms of major depression may overlap with other psychiatric disorders.

treatment

There are a variety of antidepressant medications and therapies available to those suffering from depression. Antidepressant medications help to stabilize mood. People can also learn to manage their symptoms with psychotherapy. People with a milder form of depression may benefit from psychotherapy alone, while those with more severe symptoms and episodes may benefit from antidepressants. A combination of both types of treatment is often most helpful to people. The treatments listed here are ones which research have shown to be effective for people with depression. They are considered to be evidence-based practices.

Medication

There are five different classes of antidepressant medications. The section titled "Antidepressant Medication: What You Should Know" (pages 6-7) provides general information about antidepressant medications and specific information about the different classes of antidepressants.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is a well established treatment for people with depression. CBT is a blend of two therapies: cognitive therapy and behavioral therapy. Cognitive therapy focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy. Behavioral therapy focuses on a person's actions and aims to change unhealthy behavior patterns.

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify and correct distorted thoughts or negative self talk often associated with depressed feelings, recognize and change inaccurate beliefs, engage in more enjoyable activities, relate to self and others in more positive ways, learn problem-solving skills, and change behaviors. Another focus of CBT is behavioral activation (i.e., increasing activity levels and helping the patient take part in rewarding activities which can improve mood). CBT is a structured, weekly intervention. Weekly homework assignments help the individual apply the learned techniques.

Family Psychoeducation

Mental illness affects the whole family. Family treatment can play an important role to help both the person with depression and his or her relatives. Family Psychoeducation is one way

families can work together towards recovery. The family and clinician will meet together to discuss the problems they are experiencing. Families will then attend educational sessions where they will learn basic facts about mental illness, coping skills, communication skills, problem-solving skills, and ways to work together toward recovery.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is an approach that is most effective with individuals with the greatest service needs, such as those with a history of multiple hospitalizations. In ACT, the person receives treatment from an interdisciplinary team of usually 10 to 12 professionals, including case managers, a psychiatrist, several nurses and social workers, vocational specialists, substance abuse treatment specialists, and peer specialists. The team provides coverage 24 hours, 7 days per week, and utilizes small caseloads, usually 1 staff for every 10 clients. Services provided include: case management, comprehensive treatment planning, crisis intervention, medication management, individual supportive therapy, substance abuse treatment, rehabilitation services (i.e. supported employment), and peer support.

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is a procedure used to treat severe or life-threatening depression. It is used when other treatments such as psychotherapy and antidepressant medications have not worked. Electrical currents are briefly sent to the brain through electrodes placed on the head. The electrical current can last up to 8 seconds, producing a short seizure.

It is believed this brain stimulation helps relieve symptoms of depression by altering brain chemicals, including neurotransmitters like serotonin and natural pain relievers called endorphins. ECT treatments are usually done 2 to 3 times a week for 2 to 3 weeks. Maintenance treatments may be done one time each week, tapering down to one time each month. They may continue for several months to a year, to reduce the risk of relapse. ECT is usually given in combination with medication, psychotherapy, family therapy, and behavioral therapy.

Effective treatments for major depression include medication, cognitive behavioral therapy, family psychoeducation, assertive community treatment, and (sometimes) electroconvulsive therapy.



how family members can help

The family environment is important to the recovery of people who are depressed. Even though depression can be a frustrating illness, family members can help the process of recovering from depression in many ways.

Encourage Treatment

Depression is a treatable illness. Medications, psychotherapy, and self-help measures can help a depressed person feel better and return to normal life. The first step is to visit a doctor for a thorough evaluation. If possible, family members should be present at the evaluation to offer support and help answer the doctor's questions. If the depressed person has been prescribed medication, family members can give them support in taking those medications. Taking medication can be difficult - there will be times when the person won't want to take it or may just forget to take it. Encouragement and reminders are helpful.

The person may also have been referred for psychotherapy. Family members can be very helpful in supporting attendance to psychotherapy. Some ways to do this are by giving reminders, offering support, and providing transportation to the clinic.

Provide Support

Family members can be a sympathetic ear. Talking about their feelings often helps depressed people feel better. It is best if family members can realize that the person is in pain and try to be understanding rather than critical, negative or blaming. Family members can also encourage the person to join in enjoyable activities (e.g., inviting the person out for movies or walks). It may be difficult at times, but families do best when they are patient and appreciate any progress that is being made, however slow it may be.

If family members are having difficulty being supportive, it might be because of what they believe is causing the depression. Studies show that family members try to make sense of depression by determining its cause. They tend to think about the causes of depression as "moral" or "organic." Family members who believe the cause of depression is "moral" believe depression is caused by the individual's personality (i.e., the individual is weak, lazy, or lacking self-discipline). Family members who believe the cause of depression is "organic" believe in the medical model of disease (i.e., depression is a medical illness).

The belief that depression is caused by moral weakness, laziness, or lack of self-discipline leads family members to believe that the symptoms are controllable by their relative. The belief that people have control over, and hence are responsible for their depressive symptoms, can lead to feelings of anger and may prevent family members from being supportive of their ill relative. In contrast, belief in the medical model of depression may lead family members to believe that the symptoms are not controllable, and therefore the depressed individual is not responsible for their symptoms. This leads to greater feelings of warmth and sympathy and a greater willingness to help their relative. Research has shown that family members who hold a medical view of depression are less critical of their relative than those who hold a moral view of depression. These views of what causes depression are important because critical attitudes on the part of the relative are predictive of relapse in the depressed individual.

There is a strong relationship between critical and hostile attitudes on the part of family members and relapse among people who are depressed.

Take Care of Themselves

Family members often feel guilty about spending time away from their depressed relative; however, it is important that they take good care of themselves. There are many ways to do this. Family members should not allow their depressed relative to monopolize their time. Spending

time alone or with other family members and friends is important for their own well-being. Negative thinking on the part of a depressed relative can often affect family members. Keeping a positive attitude is important! Family members may consider joining a support or therapy group. Counseling can often help family and friends better cope with a loved one's depression. Finally, family members should not feel responsible for solving the problem themselves. They can't. They should get the help of a mental health professional if needed.



Family members can help the process of recovering from depression in many ways. Some ways include encouraging treatment (medication and psychotherapy), providing support, and taking care of themselves.

antidepressant medication: what you should know

- Depression is regarded as a medical disorder (like diabetes).
- Research has found that antidepressants are effective for treating depression, but it is not clear exactly how they work.
- Brain chemicals called neurotransmitters (chemical messengers) are believed to regulate mood.
- Antidepressant medications work to increase the following neurotransmitters: serotonin, norepinephrine, and/or dopamine.
- All antidepressants must be taken as prescribed for three to four weeks before you can expect to see positive changes in your symptoms. So don't stop taking your medication because you think it's not working. Give it time!
- Sometimes the antidepressant you first try may not lead to improvements in mood. This is because each person's brain chemistry is unique; what works well for one person may not do as well for another. Be open to trying another medication or combination of medications in order to find a good fit. Studies have shown that people who did not get better after taking a first medication increased their chances of becoming symptom-free after they switched to another medication or added another medication to their existing one. Let your doctor know if your symptoms have not improved and do not give up searching for the right medication!
- Once you have responded to treatment, it is important to continue treatment. If you have only had one episode of depression, it is typical for treatment to continue for 6-9 months. Discontinuing treatment earlier may lead to a relapse of symptoms. If you have had a number of episodes of depression, your doctor may recommend longer term treatment.
- To prevent depression from coming back or worsening, do not abruptly stop taking your medications, even if you are feeling better. Stopping your medication can cause a relapse. Medication should only be stopped under your doctor's supervision. If you want to stop taking your medication, talk to your doctor about how to correctly stop them.
- If you forget to take a dose, a safe rule of thumb is: If you missed your regular time by three hours or less, you should take that dose when you remember it. If it is more than three hours after the dose should have been taken, just skip the forgotten dose and resume your medication at the next regularly scheduled time. Never double up on doses of your antidepressant to "catch up" on those you have forgotten.
- Like all medications, antidepressants can have side effects. In most cases they are mild and tend to diminish with time. Your doctor will discuss some common side effects with you. If you experience side effects, talk to your doctor before making any decisions about discontinuing treatment.
- There are five different classes of antidepressant medications. This handout lists antidepressant medications by class. Common side effects are also listed. All medicines may cause side effects, but many people have no side effects or minor side effects. The side effects people typically experience are tolerable and subside in a few days. Check with your doctor if any of the common side effects listed persist or become bothersome.

- In rare cases, these medications can cause severe side effects. Contact your doctor immediately if you experience one or more severe symptoms.



****This handout provides only general information about antidepressant medication. It does not cover all possible uses, actions, precautions, side effects, or interactions of the medicines mentioned. This information does not constitute medical advice or treatment and is not intended as medical advice for individual problems or for making an evaluation as to the risks and benefits of taking a particular medication. The treating physician, relying on experience and knowledge of the patient, must determine dosages and the best treatment for the patient.****

ANTIDEPRESSANT CLASS #1: SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)

SSRIs are the most commonly prescribed class of antidepressants because they tend to have the fewest side effects. SSRIs increase the level of serotonin by inhibiting reuptake of the neurotransmitter.

Fluoxetine (Prozac)
Citalopram (Celexa)
Sertraline (Zoloft)
Paroxetine (Paxil)
Escitalopram (Lexapro)

Common side effects for SSRI's

Abnormal dreams; anxiety; blurred vision; constipation; decreased sexual desire or ability; diarrhea; dizziness; drowsiness; dry mouth; flu-like symptoms (e.g., fever, chills, muscle aches); flushing; gas; increased sweating; increased urination; lightheadedness when you stand or sit up; loss of appetite; nausea; nervousness; runny nose; sore throat; stomach upset; stuffy nose; tiredness; trouble concentrating; trouble sleeping; yawning; vomiting; weight loss.

ANTIDEPRESSANT CLASS #2: SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)

SNRIs are similar to SSRI's in that they increase levels of serotonin in the brain. They also increase norepinephrine in the brain to improve mood.

Venlafaxine (Effexor)
Duloxetine (Cymbalta)
Desvenlafaxine (Pristiq)

Common side effects for SNRI's

Anxiety; blurred vision; changes in taste; constipation; decreased sexual desire or ability; diarrhea; dizziness; drowsiness; dry mouth; fatigue; flushing; headache; increased sweating; loss of appetite; nausea; nervousness; sore throat; stomach upset; trouble sleeping; vomiting; weakness; weight loss; yawning.

ANTIDEPRESSANT CLASS #3: ATYPICAL ANTIDEPRESSANTS

In addition to targeting serotonin and/or norepinephrine, the atypical antidepressants may also target dopamine. They also tend to have fewer side effects than the older classes of medication listed below (Antidepressant Classes 4 and 5). The common side effects differ for each of the medications in this class of antidepressants.

Bupropion (Wellbutrin)

Common side effects: Constipation; dizziness; drowsiness; dry mouth; headache; increased sweating; loss of appetite; nausea; nervousness; restlessness; taste changes; trouble sleeping; vomiting; weight changes.

Mirtazapine (Remeron)

Common side effects: Sedation, increased appetite, weight gain, dry mouth, constipation, fatigue, dizziness, low blood pressure.

Trazodone (Desyrel)

Common side effects: Blurred vision; constipation; decreased appetite; dizziness; drowsiness; dry mouth; general body discomfort; headache; light-headedness; muscle aches/pains; nausea; nervousness; sleeplessness; stomach pain; stuffy nose; swelling of the skin; tiredness; tremors.

Nefazodone (Serzone)

Common side effects: Abnormal dreams; abnormal skin sensations; changes in taste; chills; confusion; constipation; decreased concentration; decreased sex drive; diarrhea; dizziness; drowsiness; dry mouth; fever; frequent urination; headache; incoordination; increased appetite; increased cough; indigestion; lightheadedness; memory loss; mental confusion; ringing in the ears; sleeplessness; sore throat; swelling of the hands and feet; tremor; urinary retention; urinary tract infection; vaginal infection; weakness.

ANTIDEPRESSANT CLASS #4: TRICYCLICS AND TETRACYCLICS (TCA AND TECA)

This is an older class of antidepressants that also work by increasing levels of serotonin and norepinephrine in the brain. These medications are good alternatives if the newer medications are ineffective.

Amitriptyline (Elavil or Endep)
Amoxapine (Asendin)
Clomipramine (Anafranil)
Desipramine (Norpramin or Pertofrane)
Doxepin (Sinequan or Adapin)
Imipramine (Tofranil)
Nortriptyline (Pamelor)
Protriptyline (Vivactil)
Trimipramine (Surmontil)
Maprotiline (Ludiomil)

Common side effects for the TCAs

Dry mouth; constipation; pupil dilation; dizziness; drowsiness; abnormal dreams; anxiety or nervousness; blurred vision; change in appetite or weight; changes in blood pressure; change in sexual desire or ability; clumsiness; confusion; decreased memory or concentration; excess sweating; excitement; headache; heartburn; indigestion; nausea; nightmares; pounding in the chest; restlessness; stuffy nose; swelling; tiredness; tremors; trouble sleeping; upset stomach; urinary retention; vomiting; weakness.

ANTIDEPRESSANT CLASS #5: MONOAMINE OXIDASE INHIBITORS (MAOI)

MAOIs are an older class of antidepressants which are not frequently used because of the need to follow a special diet to avoid potential side effects. However, these medications can be very effective. These drugs work by blocking an enzyme called monoamine oxidase, which breaks down the brain chemicals serotonin, norepinephrine, and dopamine.

- When taking MAOIs, it is important to follow a low "tyramine" diet which avoids foods such as cheeses, pickles, and alcohol and to avoid some over-the-counter cold medications. Most people can adopt to a low tyramine diet without much difficulty. Your doctor will provide a complete list of all food, drinks, and medications to avoid.

Phenelzine (Nardil)

Tranylcypromine (Parnate)

Selegiline (Emsam) patch

Common side effects for MAOIs

Blurred vision; changes in sexual function; diarrhea, gas, constipation, or upset stomach; difficulty swallowing, or heartburn; dizziness, lightheadedness, or fainting; drowsiness; dry mouth; headache; nausea, muscle pain or weakness; purple blotches on the skin; rash, redness, irritation, or sores in the mouth (if you are taking the orally disintegrating tablets); sleep problems; stomach pain, tiredness; tremors; twitching; unusual muscle movements; vomiting, unusual dreams; upset stomach; weakness.





IMAGE BY KEVIN ROLLY

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