What is depression?

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What is depression?

People casually use the phrase, "I'm so depressed!" to let others know that they are feeling down. But a temporary case of the blues - something we all experience - has nothing to do with real depression.

True depression is not the blues, sadness or even grief. It is an overwhelming and enveloping despair so bleak and dark that people who have experienced it say that it is the worst pain they have ever endured.

Depression is a treatable mental illness. Eight percent of Canadians will experience a major depression in their lifetime.[1] Young people are particularly affected with 20% experiencing an episode of depression before the age of 20.[2] Twice the numbers of women than men are diagnosed with depression and women are 1 ½ times more likely to be hospitalized.[3] However, the suicide rate for men is four times that of women, leading researchers to speculate that men may well experience depression at the same rates as women but their view of themselves as "strong" means they are unwilling to talk about it or take medication. Instead, they tend to self-manage by using drugs or alcohol. Recent work shows that this may be changing as particularly younger men are starting to open up about their depression and seek treatment. [4]

While there have been changes in people's attitudes towards depression, researchers believe that, due to the stigma associated with mental illnesses, fully 90% of people who are experiencing the symptoms of depression struggle alone - and never seek treatment.[5] Yet, those who do enter treatment have an excellent chance of recovery. For example, of the 83% of people hospitalized in Ontario showing signs of depression, 75% were discharged with reduced symptoms.[6] Other research shows that people who receive treatment for depression respond well.[7]

What are the symptoms like?

There is no x-ray or blood test for depression. Instead, you, your family and your friends will notice that your mood, behaviour, functioning, attitudes and thoughts have changed. Many of the symptoms of depression are a case of too much – or too little. For example, you may…

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[1] Kirby, M. & Keon, W. (2004). Report 1, Mental health, mental illness and addiction: Overview of policies and programs in Canada (Chapter 5). Interim report of the Standing Senate Committee on Social Affairs, Science and Technology.

[2] Workplace mental health indicators: An EAP's perspective (2005 Series, Vol 1, Issue 1): Available at: http://www.warrenshepell.com/research/iresearch.asp

[3] Report on mental illnesses in Canada (2002). Available at: http://www.phac-aspc.gc.ca/publicat/miic-mmac/index.html

[4] O'Brien, A. (March 2009). Macho men opening up about depression: research. The Ottawa Citizen. This article briefly reviews research about men's health, including depression, from the University of British Columbia. Available at: http://www.ottawacitizen.com/health/seniors/Macho+opening+about+depression+Researchers/1386114/story.html

[5] Fact sheet: Depression in the elderly. Available at: http://www.mooddisorderscanada.ca/depression/elderly/index.htm

[6] Canadian Institute for Health Information (CIHI) (March 31, 2009). Exploring mental health service use in Ontario (2007 – 2008). Available at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=home_e

[7] Fact sheet: Depression in the elderly. Available at: http://www.mooddisorderscanada.ca/depression/elderly/index.htm

- Be sleeping little or sleeping too much.
- Have gained or lost a significant amount of weight.
- Be highly anxious and agitated or sluggish and inert.
- Have unexplained aches and pains.
- Be extremely sad or very bad tempered - or both.

You will also feel….

- A loss of interest in the pleasures of life (small and large), as well as work, family and friends.
- Unable to concentrate and make decisions.
- Negative, anxious, trapped, unable to act.
- Despairing, guilty and unworthy.
- Fatigue and an overall loss of energy.
- Suicidal – expressing thoughts and sometimes, making plans.
- Numb – an awful feeling of emptiness.

These symptoms can evolve and worsen overtime. Experts say that a diagnosis of depression is arrived at when a person has been experiencing at least five of the above symptoms for a period of two weeks or more.[8] A recent survey of Canadians showed that, while the emotional symptoms of depression are disturbing to patients, they are as much or even more concerned about the change in functioning they experience because the impact on their ability to work leaves them feeling vulnerable.[9]

A special word about the association between depression and physical pain

Researchers believe that there is a shared neural pathway for pain and depression with serotonin and norepinephrine involved in both mood and pain. People who are actually depressed often talk to their physicians *only* about their physical pain.

Research has shown that the higher the number of physical symptoms a person is experiencing, the more likely that they are suffering from depression. Depression is strongly suspected when physicians cannot find a physical source for the pain patients say they are experiencing. [10]

It is thought that depression may increase a person's sensitivity to pain or may increase the suffering associated with pain. [11]

Studies have also shown that, of those reporting nine or more physical pain symptoms, 60% had a mood disorder. When only one physical symptom was reported, only 2% were found to have mood disorder.

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[8] Antidepressant Skills Workbook (2008). Developed by the Centre for Applied Research in Mental Health and Addiction (CARMHA). Available at: http://www.comh.ca/antidepressant-skills/adult/index.cfm

[9] Watson Wyatt (June 2009) Depression study.

[10] News Canada (Sept 2010). Depression hurts but only half of Canadians know it. Available at: http://www.newscanada.com/Print-Sept-Depression-hurts-but-only-half-of-Canadians-know-it

[11] Ibid

A high number of physical pain symptoms are also predictive of a relapse even after mood has lifted. Further, people who experience chronic pain as part of their depression are more likely to also have suicidal thoughts.[12]

A range of physical symptoms associated with depression include:[13]

- Headaches
- Back pain
- Muscle and joint pain
- Chest pain
- Digestive problems and pain
- Exhaustion and fatigue
- Sleeping problems
- Change in appetite or weight
- Dizziness or lightheadedness

In addition, people with diagnosed physical illnesses such as stroke, diabetes, heart disease, or cancer (to name only a few) suffer depression in disproportionately higher numbers than the general population.[14]

Are there different types of depression?[15]

Experts have categorized different forms of depression. Any type of depression must be taken seriously, but people can experience it differently and under different circumstances.

Major depressive episode

This diagnosis is applied when you have experienced five or more of the symptoms discussed in the previous section for two weeks or longer. In addition, your symptoms have resulted in significant changes in your ability to function at work or school, and socially (with friends and family).

Some people with major depression can experience psychosis where their thinking is disordered and out of touch with reality. Given the features of depression, their thoughts are most likely to be ones that are devaluing (I'm worth nothing. The world would be a better place without me. I am making other people unhappy just by living). In the absolute rarest of cases these thoughts can evolve into an overwhelming belief that those they love must die so they can be spared the inevitable pain of living.

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[12] Trivedi, M. (2004). The link between depression and physical symptoms. Journal of Clinical Psychiatry, Primary care Companion, Vol 6 (Supplement 1), pg. 12-16.
[13] WebMD. Available at: http://www.webmd.com/depression/recognizing-depression-symptoms/physical-symptoms
[14] Mood disorders in the medically ill: Scientific review and recommendations (2005). Biological Psychiatry, Vol 58, p. 175-189.

[15] The information for this section is based on the *Diagnostic and Statistical Manual IV-TR*, a publication of the American Psychiatric Association.

A major depressive disorder can occur once in a lifetime, never to return - or episodes can be recurrent.

Depression alternating with manic episodes

People with bipolar disorder (formerly called manic depression) will experience depression interspersed with bouts of mania. Mania is defined as a persistently elevated mood lasting one week or more. “Elevated mood” means extreme happiness - but it also can mean extreme irritability. During manic episodes, people can adopt grandiose ideas of who they are or what they can do. They may involve themselves in risky behaviours (such as spending sprees or unwise sexual practices), sleep little, have a limited attention span and experience racing thoughts. Shortly, however, these “highs” change to lows as people plunge into a major depression.

Dysthymic disorder

This is a form of depression where people experience low moods for more days than not – and for a long time (two years or more). They may still continue to function at work or school but they struggle with lack of interest, poor appetite, insomnia, low self esteem, limited concentration and feelings of hopelessness. This type of depression can go on for years, leaving people thinking that this is “just the way I am” – along with a sense that everyone, but them, knows how to get along in life, be successful and have fun. People with a dysthymic disorder may – or may not have experienced bouts of major depression.

Postpartum depression

This refers to an episode of major depression just after having a baby (the formal criteria specifies within four months of giving birth).

Seasonal Affective Disorder (SAD)

This is form of depression that is thought to be triggered by the low light and grey days of winter. It is not surprising that SAD is more common in northern countries, like Canada. Many people get the winter blues, but SAD is true depression with people withdrawing, missing work and social events due to their symptoms. Treatment for mild versions of SAD can be as simple as getting outdoors more often or, for those who can afford it, taking a vacation to the sun. For severe versions of SAD, people are prescribed antidepressants and undergo “light therapy” which means daily exposure to light boxes that emit full spectrum light – just like sunlight.[16]

Diagnoses of depression are also categorized into mild (limited symptoms and minimum interruption in day-to-day functioning), moderate (stronger experiences of symptoms with a noticeable affect on functioning), severe – without psychosis (in danger of harming oneself) and severe - with psychosis (depressive symptoms accompanied by delusions - believing things that aren’t true - and hallucinations - seeing, hearing or smelling things that aren’t there).

[16] Canadian Mental Health Association. Fact sheet on seasonal affective disorder. Available at: http://www.cmha.ca/BINS/content_page.asp?cid=3-86-93

What causes depression?

The causes of depression raise the old nature – nurture debate. Is it a result of family history (genes) or difficult life experiences? The experts say that we must consider nature *and* nurture when thinking about what causes depression. The following are factors that can lead to depression – all must be considered when answering the question, what causes depression? [17]

- ***Family history*** – if close family members have experienced depression, you may be susceptible yourself. Your genetic make-up determines – to a large degree – your physiology and you may have an inherited tendency towards changes in your brain chemistry that result in depression. Your unique physiology is also involved in life changes such as the birth of a baby or menopause – both instances are associated with a greater risk of depression.
- ***Recent circumstances*** – a divorce, the death of a loved one, job loss, chronic illness, life changes such as retirement, attending a new school. These events cause stress and conflict.
- ***Past history*** – experiences of childhood abuse including sexual, physical or emotional trauma, extreme neglect or abandonment. Also experiences of trauma in adulthood (recent or past) such as domestic abuse, living with drug or alcohol abuse (in self or family members), rape, robbery, war, kidnapping, or witnessing violence – to name only a few of the traumatic events that people can be exposed to.
- ***Thoughts and behaviours*** – You may have evolved a negative world view such as thinking bad things always happen to me, things never work out no matter how hard I try, I am a bad person, and the world is a bad place. Thoughts influence mood – and vice versa.

These factors can lead to emotions and behaviours that are typical of depression; low mood, despair, sadness, anxiety and numbness. They can result in reactive behaviours such as social withdrawal and, in some cases, self-medication with drugs or alcohol as you try to manage your symptoms on your own. For example, as many as 40% of people with depression struggle with the over-use of alcohol. [18] In extreme situations, people completely neglect their self-care (they don't eat properly, don't shower, and don't take care of their living space).

All these factors, genetics, difficult life events, personality, negative thoughts, low mood, and unhelpful behaviours interact with one another, leading to the downward spiral that is called depression.

A special note about depression and chronic illness

Depression is both an outcome and a predictor of physical illness, meaning that people who are depressed are more likely to develop physical illnesses - and those who have a serious or chronic illness are more likely to develop depression.

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[17] Antidepressant Skills Workbook (2008). Developed by the Centre for Applied Research in Mental Health and Addiction (CARMHA). Available at: http://www.comh.ca/antidepressant-skills/adult/index.cfm

[18] Forty percent of people with depression struggle with over-use of alcohol. Sullivan, L, & Fiellin, D, et al. (2005). The prevalence and impact of alcohol problems in major depression: A systematic review. The American Journal of Medicine. Vol 118, pg. 330-341.

For example, people with depression are 2.6 times more likely to have a stroke and 1.35 to 1.88 times more likely to develop cancer.[19]

Conversely, 17 – 27% of people with heart disease and 22 – 29% of people with cancer develop depression.[20]

Experiencing stigma

People with mental illnesses, such as depression, identify stigma as their number one concern. They experience rejection from family and friends and are fearful about what their employer would do if they found out about their illness. They also report that they experience blaming attitudes from health and mental health professionals - rather than the compassion they need.

Stigma is not only hurtful, it is dangerous. Fear of cruel judgments can prevent people from getting help in the first place or interfere with their treatment and recovery when they do enter treatment. In the larger social context, stigma related to mental illness means that governments invest less in services, treatments and research.[21]

Self stigma

People with depression live in the same cultural context as those who stigmatize their suffering. As a result, they can hold exactly the same devaluing attitudes and blame themselves for their illness. Self-stigma is particularly insidious as it robs people of hope. They begin to feel that they deserve the rejection and poor treatment they receive.

Depression in the workplace

The symptoms of depression lead directly to consequences at work - reduced concentration, an inability to come to a decision, increased number of sick days, coming in late or leaving early, irritability with co-workers or customers, accidents (in manufacturing or industrial settings), and “presenteeism” (showing up consistently but not being productive).[22]

Stigma exists in the workplace. Co-workers can be unsympathetic – or angry as they blame the person with depression for leaving them with extra work. Employers may discipline or fire people experiencing depression because they are seen as poor performers instead of employees struggling with an illness.

The Canadian disability insurance industry has begun to raise awareness among employers about the costs associated with ignoring mental illness in the workplace. They have published figures that show that 72% of short term disability claims and 82% of long term disability claims are for mental illness, primarily depression. In

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[19] Mood disorders in the medically ill: Scientific review and recommendations (2005). Biological Psychiatry, Vol 58, p. 175-189.

[20] ibid

[21] Everett, B. (2006). Stigma: The hidden killer. Available at www.mooddisordescanada.ca

[22] The Canadian Mental Health Association. Fact sheet: depression in the workplace. Available at: http://www.cmha.ca/bins/content_page.asp?cid=3-86-87-91

fact, the fastest growing category of disability costs for Canadian employers is for depression.[23]

Economists have calculated that the annual losses to Canadian businesses due to unaddressed mental illness in the workplace are $33 billion. However, if employers take action with accommodation plans, paths to treatment and return to work programs, they will save from $5000 - $10,000 per employee per year in average wage replacement, sick leave and prescription drug costs.[24]

Many employers now offer Employee Assistance Programs (EAPs) where confidential counselors are available to assist people with interpersonal problems – and with depression. If you are experiencing depression, a call to your EAP provider may be the first step towards your recovery.

Recovery

People can and do recover from depression. Recovery means living a meaningful and healthy life – despite the challenges of a mental illness. Depression is, in fact, one of the most treatable mental illnesses.

However, for the newly diagnosed, this positive prospect may seem out of reach. The stigma associated with mental illness can mean that people suffer in silence and don't seek the help they need. As a result, they cannot start their journey towards recovery. Others may feel that asking for help shows a weakness of character and that they should follow the advice they too often get: "Just snap out of it."

In a recent Ontario study, it was found that:

- Less than half of women and men with probable depression had a physician visit for that condition.
- Only one in three men and women who were hospitalized for depression had a follow-up visit with a physician within 30 days after discharge but one in five visited an emergency room in the same time frame.
- Sixty percent of Ontarians with probable depression did not visit a physician for help within a year after being interviewed for the study.[25]

It is now much more widely accepted that people can and do recover. In a recent survey of 1587 Canadians,[26] it was found that 72% saw depression as a serious *but treatable* illness.

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[23] Mental health claims on the rise in Canada: Watson Wyatt's Staying@Work Survey (Sept 2007). Available at: www.watsonwyatt.com/canada

[24] Mental Health Works, Mental health facts. Available at: http://www.mentalhealthworks.ca/facts/index.asp

[25] Lin, E. (2009). Project for an Ontario women's health evidence-based report. Chapter 5 Depression. Available at www.powerstudy.ca

[26] Edelman (August, 2010). Depression survey. Commissioned by Pfizer, Mood Disorders Society of Canada and Shepell-fgi.

Recovery from depression has the same steps that recovery from other illnesses have. Go for help, get a diagnosis (this IS depression) and develop a plan of treatment that is tailored to your needs.

As one of the primary symptoms of depression is hopelessness, it will at first seem impossible to find hope. At the beginning of treatment, it can be helpful to talk with someone who's "been there." Someone who has struggled with their own depression knows about the steps to recovery, the possible set backs you may encounter and what it is like to believe that the darkness will never lift – until, one day, it does. They can tell you, from experience, that things will get better. As you engage with your treatment team, you will gradually become more and more active in decision-making about what is and is not working for you. This feedback is essential for your treatment professionals. Knowing what medication suits you, seeking therapy, educating yourself about your illness, and, if it is for you, participating in a self-help group are all ingredients in recovery – as are other choices that my be particular to your individual needs and circumstances.

The following sections of this brochure set out a treatment program that has been shown to work for most people.

How is depression treated?

Most people, once they acknowledge that they need help, turn to their family physician. In fact, the majority of treatment for depression in Canada is provided by family physicians.[27] As there is no lab test for depression, the family physician relies on your description of symptoms in order to make a diagnosis.

Depression is often described as a "chemical imbalance" in the brain. What this means is that certain neurotransmitters (your brain chemicals) are not at the levels they should be to maintain positive mood. The neurotransmitters that affect mood are serotonin, norepinephrine and dopamine.[28]

Medication

The most common treatment for depression involves medication designed to increase the levels of these neurotransmitters and thus, improve your mood.

One of the effects of the stigma that surrounds mental illness is shame. People can feel that the *real* treatment for depression is to pull yourself up by your boot straps. In other words – get over it. As a result, they can resist taking medication because to do so would be a clear sign that they are weak. No one would think of themselves as weak for taking medication for high blood pressure or insulin for diabetes – but people with depression can feel they have somehow failed if they resort to medication.

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[27] Slomp M, Bland R, Patterson S, & Whittaker L. (2009). Three-year physician treated prevalence rate of mental disorders in Alberta. Canadian Journal of Psychiatry. Vol 54(3), pg. 199-203.

[28] Tung, A. & Procyshyn, R. (2007). How antidepressant and antipsychotic medications work. Visions Journal. Vol 4(2), pg. 7 – 8. Available at: http://www.heretohelp.bc.ca/publications/visions/medications/bck/3

There is some evidence that people with mild depression should try other interventions first (such as psychotherapy and lifestyle changes).[29] However, severe depression requires medication (in combination with other treatments) to achieve recovery.

Medication for depression is a complex topic. There are many brands with different chemical formulas, each designed to act somewhat differently in the brain. There are also side effects to consider. And these medications do not act immediately to lift mood. They can take from two to eight weeks to begin to work – a frustrating experience if, in fact, you don't have the right medication on the first try and must now turn to something else. Stick with it – you will eventually find one that is right for you.

As some of the symptoms of depression are the inability to concentrate and difficulty in making decisions, people, when they are in the depths of an episode of depression, can benefit from solid advice from health providers and support from loved ones. Making treatment decisions is necessary - but complicated.

The following is a brief tour of the most commonly prescribed antidepressant medications.

First of all, it is useful to group the various antidepressants into families based on their chemical make-up and which neurotransmitters they are designed to affect.

Older antidepressants

Tricyclic antidepressants (TCAs) have been on the market for many years. They increase levels of serotonin and norepinephrine. Examples are *nortriptyline* (brand name Pamelor or Aventyl - also called Norventyl), *desipramine* (brand name Norpramin), a*mitriptyline* (brand name Elavil) and *imipramine* (brand name Tofranil).

Monoamine Oxidase Inhibitors (MAOIs) interfere with the breakdown of the critical neurotransmitters associated with depression and keep them at the levels that improve mood. Examples are *pheneizine*, (brand name Nardil) and *isocarboxazid* (brand name Marplan).

If many of these names are unfamiliar, it is because they belong to older classes of antidepressants but they are still prescribed as they work for some people. They do, however, have numerous side effects including drowsiness, dry mouth, weight gain, constipation, blurred vision and sexual dysfunction. Understandably, people have had trouble coping with these effects.

Newer antidepressants

These antidepressants work somewhat differently, but their main advantage is reduced side effects.

Selective Serotonin Reuptake Inhibitors (SSRIs*)* increase the levels of serotonin in the brain. Side effects include nausea, increased appetite and sexual dysfunction.

[29] Zuvekas S, Rupp A, et al. (2005). Spillover effects of benefit expansions and carve-outs on psychotropic medication use and costs. Inquiry Vol 42. pg 86-97.

Examples are *fluoxetine* (brand name Prozac), *paroxetine* (brand name Paxil), *sertraline* (brand name Zoloft), *citalopram* (brand name Celexa), and Cipralex (escitalopram).

Serotonin Norepinephrine Reuptake Inhibitor (SNRIs). This group of medications are thought to work by affecting both serotonin and norepinephrine in the brain. Examples of these antidepressants are venlafaxine XR (Effexor XR), duloxetine (Cymbalta), and *desvenlafaxine succinate (Pristiq).* [30]

Norepinephrine Dopamine Reuptake Inhibitors (NNRIs). An example of a NDRI is buproprion (Wellbutrin). They result in fewer side effects related to sexual disfunction.

Antipsychotic medications for depression. For some people, antipsychotic medication may be used in addition to antidepressants. Examples of such medication approved for this use are *q*uetiapine fumarate (Seroquel, original formula and Seroquel XR, extended release). These medications are approved for use in both the manic and the depressive phases of bipolar disorder.

> ***Special note:*** Some antidepressants are not recommended for the depressive phase of bipolar disorder because they can trigger a manic episode. Please see our brochure on Bipolar Disorder for further information. Available at: www.mooddisorderscanada.ca.

Given the ways these many antidepressants work and the various side effects, it is easy to see that finding the right medication – for your form of depression – can take time and experimentation. Ongoing consultation with your physician and pharmacist – with the support of family and friends - can help you in your search.

Electroconvulsive therapy (ECT)

ECT involves passing a brief electric current through the brain, producing seizures during the procedure. It is administered under anesthetic. ECT is used particularly for people who are not responding well to antidepressant medication or who are at high risk of suicide.[31] While research shows ECT to be effective, it remains controversial particularly in relation to reported side effects. Psychiatrists indicate the associated memory losses are minimal and memories soon return. Some people who have experienced ECT contend that their memory has been permanently altered and that the experience was dehumanizing.[32] It is important that you (or your support people – if you are not capable) investigate ECT completely before choosing this treatment for yourself.

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[30] Tung, A. & Procyshyn, R. (2007). How antidepressant and antipsychotic medications work. Visions Journal. Vol 4(2), pg. 7 – 8. Available at: http://www.heretohelp.bc.ca/publications/visions/medications/bck/3

[31] For a full discussion of ECT, see Enns, M. & Reiss, J. (2009). Electroconvulsive therapy. Canadian Psychiatric Association available at: https://ww1.cpa-apc.org/Publications/Position_Papers/Therapy.asp

[32] Raju, P. Kronick, R. & Capponi, P. (2008). Candid conversations between psychiatric residents and consumers. Canadian Psychiatry Aujour'dui. Vol 4(6). Available at: http://publications.cpa-apc.org/browse/documents/430&xwm=true

Psychotherapy

Research has shown that medication in combination with therapy is the most effective way of treating depression.[33] There are different forms of therapy. *Interpersonal* - where you and your therapist explore your past hurts, present relationships and future goals, looking at ways you can develop a more healthful life in all dimensions (physical, mental, emotional and spiritual health). *Marital or family therapy,* by definition, involves you and those close to you in joint sessions where you examine how you can relate to one another in more healthful ways. *Group therapy* brings people together who share a particular problem so they can examine together some of the common ways they have acted – or choices that they have made – that have led to difficulties in their lives. Group members also share tips and coping strategies for more healthy living.

Cognitive behavioural therapy (CBT) is the model of therapy that is most associated with the treatment for depression and/or anxiety (although it can be effective for other difficulties or illnesses). CBT has been extensively researched and has consistently shown positive results. The basic idea of CBT is that your thoughts (cognitions) affect how you feel (mood) and lead to your actions (behaviours). After a while, there is an entrenched cycle where it is hard to determine which came first; negative thoughts and moods leading to unhealthy behaviours, or unhealthy behaviours leading to negative moods and thoughts.

As the central set of symptoms for depression are negative thoughts, despairing moods and isolating behaviours, it is easy to see that CBT could be helpful. CBT brings these thought/mood/action connections to light through structured exercises and shows you how your inner negative self-talk brings you down emotionally and leads to behaviours that are unhealthy for you – while offering step-by-step strategies for change.

Psychoeducation and self education/management

Psychoeducation is the name for formal education groups – run by mental health professionals – that help you (and in some cases, family and friends) understand the dynamics of depression, treatment options and the resources available to help.

Self-education/management is central to empowerment and recovery. It means that you begin to take personal responsibility for learning all you can about your illness and actively search out and try coping mechanisms that improve your self-management skills aimed at preventing relapse.

Peer support and self-help

Many people find that there is no substitute for being among others who have "been there." Peers are not professional caregivers but fellow travelers who have suffered depression and struggled with recovery – just like you. In rare instances, peers can be paid by mental health organizations to visits clients and provide support or run peer programs. Most often, they are unpaid volunteers wanting to give back – or prevent others from experiencing some of the suffering they have gone through. Self-help or mutual aid is another form of peer support where peers get together in

[33] Revue sante mentale au Quebec – psychiatrie (Fall 2008). Interpersonal Psychotherapy. A special edition devoted to research into therapy for people with depression.

groups. The hallmark of self-help is *safety* – you are among people who understand so you can speak your mind without fear of judgment. No one is an "expert" and you are not alone in your struggle. Everyone has something to give and all members participate in both giving and receiving support.

Complementary, alternative and traditional therapies

Many people with depression include a variety of treatments in their recovery regime, in addition to medication and therapy. Western medicine is practiced by physicians, nurses and other allied health professionals and involves the diagnosis and treatment of illnesses. Complementary therapies are used along with Western approaches and can include massage, dietary supplements, yoga, mediation, art therapy and many other non-medical approaches. Alternative therapies are all these things but they are used instead of Western medicine. Traditional therapies are tied to your culture. Examples include Traditional Chinese Medicine (TCM), acupuncture, Ayurvedic medicine and Aboriginal healing rituals, medicines and ceremonies – but there are many more examples, depending on your particular culture.

The basics – a safe place to stay, an income and food on the table

The basic necessities of life are not "treatment" but treatment will be ineffective if they are not in place. Some people with depression live on the streets, in shelters or in sub-standard housing. They struggle with the extremes of poverty and don't know where their next meal is coming from. Such living situations are dehumanizing and dangerous. There are many community services designed to address the basics of life. When people are housed and safe, they have the foundation for treatment for mental illness or substance abuse problems if they choose this path.

Family and caregivers

While there is no doubt that the person who is experiencing depression is suffering, those who care for them are also in pain. Family and friends want to help but are often at a loss as to what to do, particularly in the face of some of the symptoms of depression which are anxiety, irritability, withdrawal, an ongoing preoccupation with negative thoughts, and a general "nothing will ever turn out for me" view of life. In addition, no family is without the baggage of past hurts and difficult interactions.

People who have recovered from depression (and families who have lived through the depression of a loved one) have developed ideas about what does and does not work. Here are some suggestions:

Educate yourself – Families and friends need to know first, *this is depression*, and they need to understand what forms of treatments are available.

This is an illness – People with depression cannot be argued out of their symptoms – just like it's obviously not helpful to tell people with a heart condition to ignore how they feel so that they can get better.

Deal with practical here and now issues – People with depression are not capable (at the time) of dealing with complicated plans or long conversations.

Avoid trying to reason people out of their negative feelings and beliefs – These are the symptoms of depression requiring treatment. While they are, indeed,

unreasonable, people in the depths of depression do not respond to reason. However, if the person is expressing ideas about harming themselves, they must know that family or friends will intervene by taking them to a physician or the emergency department. In extreme situations, it may be necessary to call the police – if the danger is imminent.

Take care of yourself – Families and friends suffer too. They need their own circle of supports and possible treatment for their mental health. There are self-help groups especially for families where they can get advice, receive support from others who are going through what they are and exchange thoughts on coping mechanisms.[34]

As a special note for family members or friends who wish to know the details of their adult loved one's treatment from mental health professionals, they must obtain signed permission from their loved one under the provisions of the Mental Health Act. The exact details of this requirement may vary from province to province but the principle of privacy remains is similar. Mental health professionals may not share information about a client's treatment (outside the treatment team) without written permission from the client. Check with your province's legislation to see what the requirements are for you.

Leading a balanced life

Just like those who've had a heart attack or other physical illnesses, people who've experienced depression need to examine their habits and lifestyle. Living for a period in the depths of depression likely means you have neglected your diet, have become inactive and may be socially isolated. You may also have become dependent on drugs or alcohol – a common coping mechanism but one which increases, rather than reduces the pain of depression. Nutrition, exercise, sleeping properly, reconnecting with friends and developing healthy skills to cope with stress are important to your recovery. In fact, exercise (even a little) has been shown to relieve the symptoms of depression.[35] It may be hard to begin a new program of self-care after months of inertia, but taking a long hard look at your lifestyle and making adjustments leads to an improved sense of self esteem and self confidence – and a more balanced life.

What does the future hold?

Research into the causes and treatments for depression continues to evolve. For example, pharmaceutical research focuses on new drugs that have fewer side effects or those with new chemical formulas. There is also promising research on the genetic components of depression and more effective ways of diagnosing depression.[36]

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[34] Mood disorders – Help for families and partners. See: http://www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/mood_disorders_partfamilies.html Also see Support for Families and Caregivers at: http://www.ontario.cmha.ca/family_resources.asp

[35] Tips from the Mayo Clinic staff. Available at: http://www.mayoclinic.com/health/depression-and-exercise/MH00043

[36] Young, L. (2008). New treatments for depression. Best Health Magazine. (Note that this is a commercial site). See full article at: http://www.besthealthmag.ca/embrace-life/mental-health/new-treatments-for-depression

Transcranial magnetic stimulation (TMS) involves the stimulation of very specific localized areas of the brain. Research has shown positive results in the treatment of depression but also in cases of stroke and other neurological disorders – although scientists caution that further study is required, especially for what is called "treatment resistant depression."[37] TMS also has the advantage of producing fewer side effects than ECT with no memory or cognitive losses reported. TMS does not require anesthetic and can be administered on an outpatient basis. The only side effect noted is a mild headache. TMS was licensed for use in Canada in November 2005.[38]

There have also been advances in the self-management of depression. Numerous helpful guides and workbooks exist. They focus on what you can do to manage your own symptoms and prevent relapse. Taking charge of your own health is key to recovery. A search of the web under "self-management of depression" will offer you many choices in free, highly practical and readable downloadable tools. Not all will work for everyone – but with the numbers available, there will be one that makes sense for you.

In addition to these sorts of self-management tools, there are scientific advances in computerized self-help programs for depression. One notable program has been developed by the National Space Biomedical Research Institute (a research partnership sponsored by NASA). These scientists have developed a self-guided computerized treatment program for depression to be used by astronauts on long space missions such as participation with the International Space Station. The program has been tested in the Antarctic where scientists and others spend long periods of isolation and has achieved, so far, positive reports from users. It is also thought that the program could have use in rural and remote communities where people don't have easy access to mental health experts.[39]

Where can I get more information?

The Mood Disorders Society of Canada (MDSC) is a national, not-for-profit, registered charitable organization that is volunteer-driven and committed to improving the quality of life for those Canadians living with mood disorders and their families. The website (www.mooddisorderscanada.ca) contains more information on depression, bipolar disorder as well as other mood disorders, contact information for finding mental health services and links to most provincial Mood Disorders Associations. Of particular note is a popular MDSC publication called *Quick Facts*, also available on the website, which offers hundreds of facts about mental health and mental illness in an easy-to-find format. If you need further assistance contact us directly through our website or at the number below.

Tel: 1 519 824 5565

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[37] Lam, R. et al (2008). Repetitive transcranial magnetic stimulation for treatment resistant depression: A systematic review and meta-analysis. Canadian Journal of Psychiatry. Vol 53(9), pg. 621 – 630.

[38] Canadian Agency for Drugs and Technology in Health (CADTH). Transcranial magnetic stimulation may aid in stroke rehabilitation. Available at: http://www.cadth.ca/index.php/en/hta/reports-publications/health-technology-update/issue4/transcranial

[39] For more information, see Science News (Sept 24, 2008) at http://esciencenews.com/articles/2008/09/24/coming.soon.self.guided.computer.based.depression.treatment

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