UNDERSTANDING DEPRESSION

INTRODUCTION

Depression is one of the most common mental illnesses in the United States. Depression affects millions of children, adolescents, adults, and the elderly and it not only inflicts significant emotional and psychological pain but depression increases mortality rates, decreases workplace productivity, and it is one the major causes of suicide. Despite many years of research the cause or causes of depression have not been clearly outlined, but with psychotherapy and the judicious use of antidepressants many people who have depression can be helped. For many people getting help and overcoming the stigma of depression are big obstacles and there are a significant number of cases that go undiagnosed.

Note: This module will discuss two of the most common types of depression, major depressive disorder and persistent depressive disorder, which is also called dysthymia. At times these disorders will be identified specifically by name and at other times the more generic term depression will be used for both.

STATEMENT OF PURPOSE

This module will provide Certified Nursing Assistants (CNAs) with basic information about the etiology and signs and symptoms of major depressive disorder and dysthymia and how these illnesses are treated.
THE STATISTICS OF DEPRESSION

It is not possible to determine the exact incidence of depression. Many people do not seek treatment, many cases of depression are not recognized by healthcare providers, and there is no requirement for reporting the disease.

However, there is ample evidence that clearly shows that depression is a very common mental illness. It has been estimated that the lifetime incidence of depression in women is 20% and 12% in men and at any single point in time depression affects approximately 10% of the population in the United States. Depression is most common in adults aged 18 to 29, but approximately 2% of school-aged children and almost 5% of adolescents have been reported to have depression. The disease is especially severe in the elderly and in this population depression can easily go undetected and undiagnosed.

These statistics are for major depressive disorder. Major depressive disorder is one of the most common depressive disorders and it has been extensively studied, so statistics for this form of the disease are easily available and commonly used to illustrate the extent of depression in any particular population. The prevalence of dysthymia has been estimated to be 6% - not as common as major depressive disorder but still significant.

THE DIAGNOSIS OF DEPRESSION
Depression is not a single disease. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), recognizes seven types of depressive disorders and some of these have what could be called sub-types. For example: Some one can be diagnosed as having major depressive disorder with mixed features; with mood-congruent psychotic features, or with; peripartum onset (The last of these is typically called post-partum depression).

This module will focus of two types of depression that are common and may be encountered during your practice as a CNA: major depressive disorder and persistent depressive disorder, also called dysthymia.

**Major Depressive Disorder**

Major depressive disorder is the form of the disease that most people think of when they think of depression, and the DSM-5 notes that major depressive disorder “... represents the classic condition in this group of disorders.” The diagnosis of major depression can be made if a patient has five or more of the following symptoms listed in Table 1; these symptoms have been consistently present for two weeks; the symptoms represent a major life change or change in mood, and; at least one of the symptoms is depressed mood or loss of interest or pleasure. Depending on the clinical picture major depressive disorder is categorized as mild, moderate, or severe.
**Table 1: Symptoms Used to Diagnose Major Depression**

1. The patient has a depressed mood for most of the day and almost every day. The depressed mood can be reported by the patient or observed by others. For children or adolescents an irritable mood can be substituted for depressed mood when making the diagnosis.

2. The depressed patient has little or no interest in pleasure and this extends to essentially every day-to-day activity. In addition, this lack of pleasure occurs every day or almost every day. As with symptom number 1, the lack of pleasure can be reported by the patient or observed.

3. There is significant weight loss but the patient is not dieting or there is significant weight gain of more than 5% of baseline body weight within a one month period, or appetite is noticeably decreased or increased nearly every day. In children, substitute failure to make expected weight gain for weight loss or changes in appetite.

4. Insomnia or hypersomnia (excessive sleeping) nearly every day.

5. The patient is either very restless (this is called psychomotor agitation) or her/his activity level is noticeably decreased (this is called psychomotor retardation), and these must be
observable, not subjective. As with the other symptoms of this list, restlessness or decreased activity must be present almost every day for the diagnosis of major depression to be considered.

6. Fatigue or loss of energy nearly every day.

7. The patient feels worthless or he/she has excessive and unrealistic feeling of guilt nearly every day. The feelings of guilt may at times be very intense and overwhelming.

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day; this can be subjective or objective.

9. Recurring thoughts of death or recurring suicidal ideation but no specific plan for committing suicide or a suicide attempt or a specific plan or committing suicide.

These symptoms cannot be attributed to a substance use disorder, medication side effect, or a medical condition and they must be the source of serious interruptions to someone’s occupational, personal, or social life for a diagnosis of major depressive disorder to be made. Major depression is not simply a passing feeling of sadness. It is a persistent condition that causes noticeable changes in a person’s activities and moods, robs them of the pleasures of living and seriously disrupts her/his occupational, personal, and social life, and puts the depressed person at risk for suicide. The impairments of major
depressive disorder may be relatively mild but they can also be completely incapacitating.

**Persistent Depressive Disorder**

Persistent depressive disorder/dysthymia and major depressive disorder share many similar characteristics but they do differ in the duration of symptoms, the number of symptoms used to make the diagnosis, and the intensity of the symptoms. The diagnostic criteria for persistent depressive disorder are:

1. A depressed mood for most of the day, a depressed mood that is present more often than absent, and at least a two year duration of a depressed mood. The depressed mood can be subjective or objective. For children or adolescents an irritable mood can be substituted for depressed mood when making the diagnosis and the depressed mood must be present for at least one year.

2. The depressed mood will be accompanied by two or more of the following.
   - Poor appetite or overeating.
   - Insomnia or hypersomnia.
   - Low energy or fatigue.
   - Low self-esteem.
   - Poor concentration or difficulty making decisions.
• Feelings of hopelessness.

3. During the two year period (one year for children/adolescents) the depressed mood or the symptoms listed in number 2 have never been absent for more than two months at a time.

4. The patient has never had a manic or hypomanic episode (Note: A hypomanic episode is similar to a manic episode but it is less severe)

5. The disorder causes significant problems in the patient’s occupational, personal, or social life.

6. The depressed mood and the symptoms are not explained by a medical condition, a drug side effect, a substance use disorder, or another significant psychiatric illness such as schizophrenia.

Depending on the clinical picture, dysthymia is categorized as mild, moderate, or severe.

Learning Break: People who have major depressive disorder or dysthymia are at risk for developing other serious psychiatric illnesses such as anorexia nervosa, borderline personality disorder, bulimia nervosa, obsessive compulsive disorder, panic disorder, and substance use disorders.

Suicide and Depressive Disorders
Major depressive disorder is one of the most common causes of suicide, and the possibility of suicide and/or suicidal behavior is always present during a serious depression. Depression is considered to be a major factor in more than one half of all suicide attempts, and it has been estimated that the lifetime risk for suicide in people who are depressed and are not treated is 20%. Male gender sex, prior suicide attempts, living alone, and feelings of hopelessness increase the risk for suicide, as does the presence of borderline personality disorder. Dysthymia has been reported to almost double the risk for suicide.

**Signs/Symptoms of Major Depressive Disorder and Dysthymia**

The signs and symptoms that characterize major depressive disorder and dysthymia and that are used to diagnose these diseases were listed in the previous section. Some of these are technical in nature and they do not represent everything that may be seen in a patient who has major depressive disorder or dysthymia. In addition to a feeling of sadness, hopelessness, and lack of pleasure someone who has major depressive disorder or dysthymia may also:

- Express anger
- Behave recklessly
- Begin abusing illicit substances
- Become agitated
- Have difficulty concentrating
- Neglect personal appearance and become sloppy with personal care habits.
- Miss work or have a decline in work performance
- Become socially withdrawn
- Have a preoccupation with death
- Contact people with the intent to say goodbye
- Begin putting her/his affairs in order
- Have a noticeable change from being very depressed to being unnaturally calm
- Stop taking medications or neglect personal health
- Complain of physical symptoms such as fatigue, headache, pain, or memory problems; this is common in older adults who have a depressive disorder

**The Progression of Major Depressive Disorder and Dysthymia**

The natural history of major depressive disorder is quite variable. With the right treatment 70%-80% of patients will have a significant improvement in mood and a significant reduction in the intensity of their symptoms. Some people may have long periods of time during which they are symptom-free while others may almost never have a remission. People who have major depressive disorder and a significant level of anxiety, psychotic features accompanying the depression, a substance use disorder, and/or another serious
psychiatric problem are less likely to have remissions or respond to treatment. Other factors that influence the course of major depressive disorder are the severity of symptoms; the duration of symptoms; young age; multiple episodes of depression, and; the length of time after symptom onset that treatment begins. If a patient has even mild symptoms of depression during a remission this is a strong predictor that a major depressive episode will recur. With appropriate treatment, 70-80% of individuals with major depressive disorder can achieve a significant reduction in symptoms. However, this encouraging statistic is offset by the fact that major depressive disorder tends to return, even after a remission or improvement of symptoms. It has been estimated that within two years after recovery from a major episode of depression about 40% of all patients will have another major depressive episode (a recurrence) and within five years this figure increases to approximately 75%.

People who have dysthymia are, by definition, burdened with a chronic disease. Dysthymia can be just as disabling as major depressive disorder and there is high risk that someone who has this depressive disorder will develop major depression or bipolar disorder, and the depression is often resistant to treatment.

**Screening for Depression**
The description of the signs and symptoms of these depressive disorders can lead the reader to assume that they are obvious and someone who has major depressive disorder or dysthymia can be easily identified. This is certainly true in many cases. But the clinical presentations of major depressive disorder and dysthymia can be subtle and their presence can be overlooked (as is often the case in a primary care setting) so screening for depression should be a part of routine health care. The US Preventive Services Task Force in their 2014 Guide to Clinical Preventive Services makes the following recommendation:

Non-pregnant adults who are age 18 and older should be screened for depression if staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. Staff-assisted depression care supports indicates that there is clinical staff that assists the primary care clinician and can provide some direct depression care and/or coordination, case management, or mental health treatment.

The Task Force recommendations also point out that there are specific risk factors for depression and people at increased risk for depression include “. . . persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are
unemployed or of lower socioeconomic status . . . (and that) women are at increased risk compared with men.”

**Note:** The recommendations specify non-pregnant adults because pregnant women have needs for preventive screening that are particular to them.

There are many tools and questionnaires that can be used to screen for depression. One of the commonly used ones is the Patient Health Questionnaire-9, aka the PHQ-9. It is quick and easy to use and has been shown to be very sensitive at detecting depression. There is also a shorter two question version of the PHQ-9, the PHQ-2. The PHQ-2 can be used as needed and if results of the PHQ-2 suggest the presence of depression, the PHQ-9 can be applied.

**Table 2: Patient Health Questionnaire- 9 (PHQ-9)**

Over the past two weeks how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Trouble falling asleep, staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Feeling bad about yourself or that you are a failure or have let yourself or your family down
6. Poor appetite or overeating
7. Trouble concentrating on things such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you have been moving around much more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way
The patient should also be asked this: How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? (Note: This question is not scored).

As regards the scored questions the patient can answer:
1) Not at all;
2) Several days;
3) More than half the days, or;
4) Nearly every day.

The answers are scored 0, 1, 2, and 3, respectively and a patient is considered to be mildly depressed if he/she has a score of 5 and severely depressed if the score is 20 or above.

As mentioned previously the presentation of depression in older adults can be different and there are depression screening tools that are designed to be used for this population. Elderly patients can be screened using PHQ-2 or PHQ-9 and if there are indications that the patient is depressed then the 15 item Geriatric Depression Scale screening test can be used.

**Table 3: Geriatric Depression Scale**

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think most people are better off than you are?

These are yes or no questions and if the patient has more than five answers that are suggestive of depression (eg, yes to number 3 and no to number 11) than depression is likely and follow-up is indicated.

Learning Break: It is important to remember that an elderly person who has a depressive disorder is much more likely to have a physical complaint than an emotional or psychological compliant. An elderly patient may be depressed but she/he will report symptoms such as fatigue or lack of energy rather than tell someone of feeling sad or hopeless. This can also be true for people of certain cultures.

CAUSES OF MAJOR DEPRESSIVE DISORDER AND DYSTHYMIA
The cause or causes of major depressive disorder and dysthymia are unknown, but both are probably the result of a complex interplay between biology, genetics, environment, and personality. In simpler terms, someone is born with a susceptibility to major depressive disorder or dysthymia and the disease develops because that individual is exposed to specific risk factors.

**Genetics and Biology**

Major depressive disorder and dysthymia are similar to many chronic diseases; there is very convincing evidence that they can be inherited but researchers have not found a single specific defective gene that is responsible for depression. For example, first-degree family members such as children or siblings of someone who has major depressive disorder are two to four times more likely to develop the same condition as would be a random member of the general population. The heritability of major depressive disorder has been estimated to be 40%-50%, and dysthymia is also considered to have a high degree of heritability. However, there are many people who develop a depressive disorder who do not have a family history of these diseases. Much more promise has been shown in identifying biological factors as a cause for major depressive disorder and dysthymia. Detailed imaging studies of the brain and other research, along with the successful use of certain antidepressants, strongly suggests that people who are
depressed have abnormal activity of the neurotransmitter serotonin. Neurotransmitters are the primary way that nerve impulses from the brain are transmitted to other areas of the brain and to the peripheral organs. Serotonin is a neurotransmitter that is found in the part of the brain that controls appetite, emotions, mood, and sex. There is some evidence that people who have a depressive order have defects in how their brains process serotonin, and this theory is supported by the success of antidepressants such as fluoxetine and paroxetine. These drugs increase the level of serotonin in the brain and this in turn diminishes the signs and symptoms of depression.

**Environment and Personality**

Depressive disorders can occur without outside stressors, but there are life events that can initiate depression. There are also personality characteristics that can pre-dispose someone to developing depression.

**Table 4: Environmental/Personality Risk Factors for Depression**

- Chronic stress
- Grief
- Adverse childhood experiences
- Loss of a loved one or family member
- Chronic illness
- Social isolation
• Negative life events
• Chronic pain
• Maladaptive coping strategies
• Personality disorders

THE TREATMENT OF MAJOR DEPRESSIVE DISORDER AND DYSTHYMIA

Major depressive disorder and dysthymia can be successfully treated. Clinical experience unequivocally shows that if a patient who has a major depressive disorder or dysthymia is treated correctly and in a timely manner then his/her symptoms will improve and a lasting remission will be seen.

Pharmacotherapy and psychotherapy are the two primary ways that major depressive disorder and dysthymia can be treated. Either one when used as a single mode of therapy has been shown to be effective and they appear to be equal in producing results. In addition there is no way to determine which patients will respond better to one or the other. However, a combination of pharmacotherapy and psychotherapy is the preferred approach as many studies have shown that combination therapy is superior to either pharmacotherapy alone or psychotherapy alone. Of course there are individual circumstances to consider when choosing a treatment. Some patients may have a medical condition that prevents them from taking antidepressants; the
side effects of these drugs may be intolerable; psychotherapy may be cost-prohibitive or unavailable; the patient may not want to take a medication, or; he/she may simply prefer one type of therapy over another.

**Pharmacotherapy**

There is a wide variety of antidepressant medications that can be used to treat someone who has depression: the most commonly prescribed are listed in Table 5. This list is not all inclusive: there are more drugs in each class than what is in the list and there are also antidepressant products that are a combination of medications, eg, fluoxetine and an atypical antipsychotic.

**Table 5: Commonly Prescribed Antidepressants**

Atypical antidepressants: Bupropion, mirtazapine, trazodone  
Monoamine oxidase inhibitors: Phenelzine, selegiline  
Selective serotonin re-uptake inhibitors: Citalopram, escitalopram, fluoxetine, paroxetine, sertraline  
Tricyclic antidepressants: Amitriptyline, doxepin, imipramine

All of the antidepressants can reduce the severity of depressive symptoms and produce a remission, but attentive readers will notice that there are more selective serotonin re-uptake inhibitors (SSRIs) in Table 5 than other medications and for good reason.

**Selective Serotonin Re-uptake Inhibitors**

The SSRIs have become the most commonly prescribed and popular drug for the treatment of depression. The SSRIs have been shown to
be at least as effective at treating depression as the monoamine oxidase inhibitors (MAOIs), the tricyclic antidepressants (TCAs), and the atypical antidepressants and they have several significant advantages over these drugs.

- **Safety:** People who are depressed are at high risk for committing suicide and taking a drug overdose is a common method of trying to cause self-harm. The MAOIs and the TCAs can be very dangerous when taken in overdose and an amount of bupropion that is just slightly above the top normal dosing range can cause arrhythmias and seizures. The SSRIs have been used in the United States since the late ’80s - about 40 years - and experience has shown that even when a very large amount of an SSRI is ingested, serious adverse effects are uncommon and death is rare. In addition, the MAOIs require careful attention to diet as there are drug-food interactions that can be potentially harmful.

- **Side effects:** The SSRIs have side effects as do all medications. But when compared to the MAOIs and the TCAs the side effects of the SSRIs are relatively mild and many patients find these drugs easier to tolerate than MAOIs and TCAs.
The SSRIs then are considered to the first-choice drug for the treatment of major depressive disorder and dysthymia and this module will focus on their uses, advantages, and side effects. Table 6 lists the SSRIs that are currently available in the United States; these are all oral medications. The generic name is given first and the trade name is in parentheses.

### Table 6: SSRIs Available in the United States

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Vilazodone (Viibryd)
- Vortioxetine (Brintellix)

The SSRIs work by inhibiting the re-uptake of serotonin. Serotonin is a neurotransmitter that is found in the part of the brain that control appetite, emotions, mood, and sex. Serotonin is released from nerve endings, stimulates a specific area of the brain, it produces a certain effect, and serotonin is then returned back to the nerve endings. The SSRIs inhibit the re-uptake of serotonin back into the nerve endings, increasing the amount of available serotonin. The theory of SSRIs and their effect on depression is that with more circulating serotonin the area of the brain that controls emotions and mood is consistently stimulated and the patient is less depressed.
There are many SSRIs and there is no evidence that indicates any particular SSRI is more effective than any other drug in this class. The patient is started on the lowest dose that can be prescribed and this can be gradually increased as needed. Using amounts that are higher then the recommended maximum will not be useful and should not be done. A noticeable improvement in symptoms usually occurs one to two weeks after starting therapy with an SSRI. If the patient does not have a good response after six to eight weeks of therapy the prescriber should consider switching to another SSRI. The usual duration of therapy with an SSRI, if this is the first major depressive episode, is four to nine months. Patients who have had two or more major depressive episodes may need a longer course of therapy. The SSRIs have fewer and more tolerable side effect than the other anti-depressants, but as with any drug they can produce unpleasant signs and symptoms. Some of these side effects such as headache, sedation, and fatigue may be mild but some are serious enough that patients discontinue taking the SSRI; one study estimated that up to 43% of all patients taking an SSRI had stopped taking the drug within three months of beginning therapy. Two side effects of the SSRIs that are very common and quite distressing for patients are weight gain and decreased libido and other sexual side effects. Approximately 25% of all people who take an SSRI will gain some weight and this can be
as much as 50 pounds. A decreased libido and other sexual side effects (e.g., difficulty attaining orgasm) are less common but still a problem nonetheless. Everyone reacts differently to the SSRIs so if a patient cannot tolerate one SSRI, she/he should be prescribed another.

**Learning Break:** There have been reports that the use of SSRIs actually increased the risk of suicide, especially when these drugs are prescribed for children, adolescents, and young adults who have major depressive disorder. The prescribing information for each SSRI has a warning that states when an SSRI is used for these patient populations the benefits and risks must be carefully examined and *the patients must be closely observed for suicidal ideation or behaviors.*

Three other important issues concerning the SSRIs are stopping therapy with an SSRI, the discontinuation syndrome, and drug interactions.

Therapy with an SSRI should never be simply stopped. The dose of these drugs must be slowly tapered, usually over a period of two to four weeks. If therapy with an SSRI is just stopped or is tapered too quickly patients can suffer from the discontinuation syndrome. The discontinuation syndrome causes a wide range of non-specific symptoms such as dizziness, fatigue, headache, and nausea and although the syndrome is usually mild and only lasts one to two weeks it can be severe and have a longer duration.
Drug interactions between the SSRIs and other medications, especially other anti-depressants, can cause serious harm. Example: The concurrent use of two medications that both have an effect on serotonin re-uptake or serotonin metabolism can lead to an excess of this neurotransmitter and a potentially fatal condition called serotonin syndrome.

**Psychotherapy**

There are many mainstream psychotherapies that can, and have been used successfully to treat patients who have major depressive disorder and dysthymia. Cognitive behavioral therapy, group therapy, interpersonal psychotherapy, and supportive psychotherapy are examples of helpful psychotherapeutic approaches, and there is no evidence that one type of psychotherapy is superior to another for treating patients who have these depressive illnesses: the specific psychotherapy that is used will depend on availability and patient preference.

**Alternative Therapies and Self-Help**

Pharmacotherapy and psychotherapy are the mainstays of treatment for patients who have major depressive disorder or dysthymia. However, depression can be very difficult to treat and antidepressants and the help of a psychotherapist may not be enough to reduce the
intensity of depressive signs and symptoms. Alternative therapies and self-help can be useful adjuncts that may make the difference.

There are many alternative therapies that have been used as treatments for depressive disorders, including (but not limited to) electroconvulsive therapy (ECT), the over-the-counter supplements St John’s wort, SAMe (S-adenosylmethionine), and omega-3 fatty acids, acupuncture, and music therapy. Aside from ECT these alternative therapies have not been well studied and it is not clear how effective they can be. In and of themselves they would be unlikely to cause harm; the harm would be in substituting an unproven alternative therapy for pharmacotherapy and/or psychotherapy.

**Learning Break:** Electroconvulsive therapy, commonly known as shock therapy, has been used for decades to treat patients who have severe, treatment-resistant depression. In ECT the patient is sedated, electrodes are attached to the skull, and a powerful electric current is administered. This current causes seizures and although the mechanism of action is not clearly understood, these induced seizures can significantly reduce the severity of depression.

**Self-help** is an essential part of treatment for depression. These activities can do much to brighten a patient’s mood, and they can help break the vicious cycle of decreased activity and social isolation caused
by depression that leads to a worsening of depressed feelings. Self-help activities include:

**Activity:** People who are depressed often have no energy for, or interest in doing anything. Unfortunately, inactivity worsens feelings of depression so patients should be encouraged to be active and involved.

**Compliance:** Following the treatment plan that has been prescribed is very important. Skipping therapy sessions and/or not taking antidepressants as prescribed will slow down or stop the recovery process.

**Exercise:** Exercise has been shown to be a very effective mood brightener and it has many other health benefits, as well. Many healthcare providers recommend exercise as a therapy for patients who have depression.

**Healthy habits:** The patient should be encouraged to maintain good health habits. For example, overeating or under eating or the use of alcohol or drugs may give someone temporary feelings of relief and distraction from depression but alcohol itself is a depressant, alcohol and drugs are addicting and harmful, and a poor diet can cause a lack of energy and health problems.
Sleep: People who are depressed often do not get enough sleep or sleep too much, and too little or too much sleep can exacerbate feelings of depression.

Socialize: People who are depressed often do not want to socialize. However, just as inactivity can increase the intensity of depression so can social isolation and although someone who is depressed often does not want to interact, being alone can be harmful and unhealthy. Patients should be encouraged to socialize - or least not to isolate themselves.

Support groups: Comparing experiences can be a helpful way of recovering from and managing depression, and the patient’s primary care provider or therapist can provide contact information for support groups.

Patience: Depression can be successfully treated but recovery is a long process. It takes time for antidepressants to begin working and finding the right type of therapy and/or medication is often a process of trial and error. Patients want to feel better as fast as possible and if it appears to them that the treatment plan is not working, there may be a strong temptation to feel that there is no hope and to give up. It can be difficult to be patient during the recovery process but it is essential.
SUMMARY

Depression is one of the most common and serious mental illnesses. Depression affects millions of children, adolescents, adults, and the elderly and it not only inflicts significant emotional and psychological pain but depression increases mortality rates, decreases workplace productivity, and it is one the major causes of suicide. The cause or causes of depression are not clearly understood but research suggests that depression is probably due to a genetic susceptibility to the disease, biological factors, and exposure to environmental stressors that act as triggers and initiate the disease process.

The signs and symptoms of depression are different for each person but feelings of hopelessness and sadness, fatigue and lack of energy, and disinterest in daily activities are very common. Major depressive disorder is one of the most common causes of suicide, and dysthymia has been reported to almost double the risk for suicide. A combination of pharmacotherapy and psychotherapy is the recommended approach for treating patients who have major depressive disorder or dysthymia, but either one of these can be used alone. Depression can be successfully treated but this can be a long process and relapses are possible. Successful treatment of depression
depends on early detection, the prompt use of the correct therapies, and patient compliance with the treatment plan.