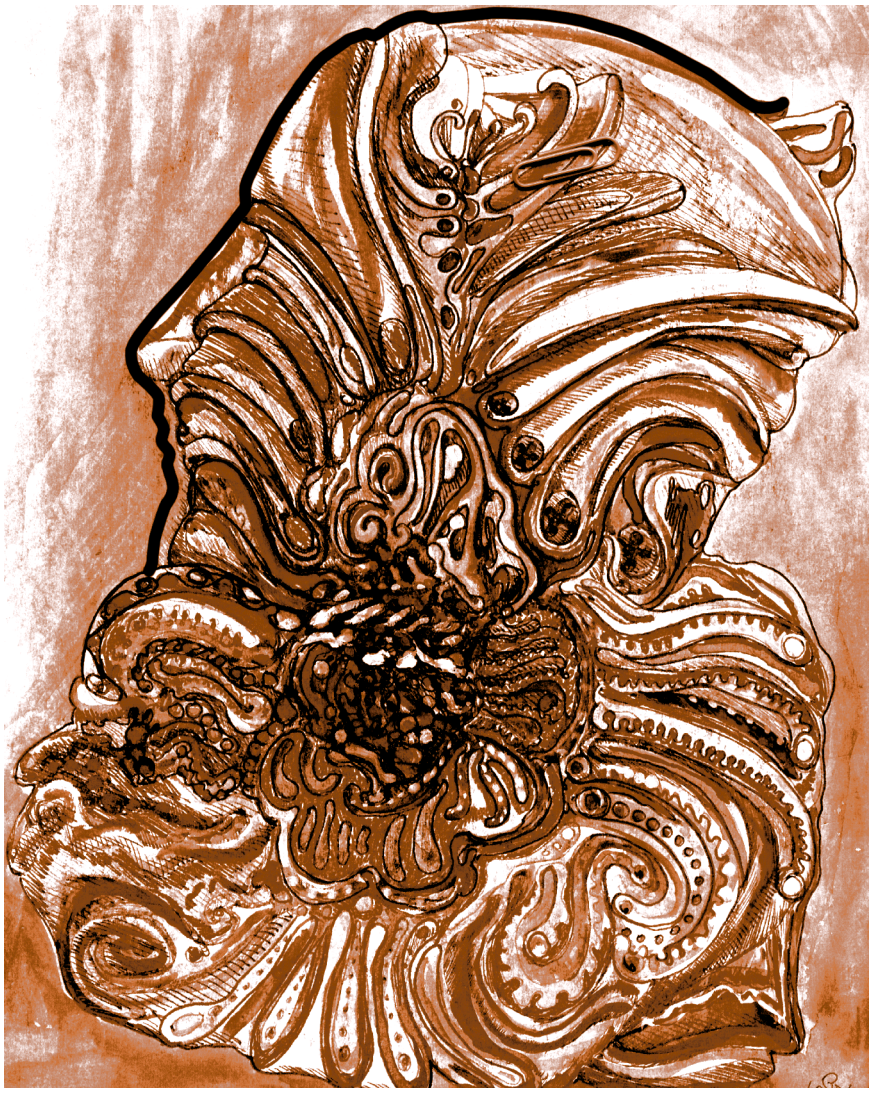
No. 11, Fall 2000

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Visions

BC's Mental Health Journal

Mood Disorders



"Seamless Armour" by Bill Pope (full-colour original)

Recognizing the Faces of Major Depression

Raymond W. Lam, MD, FRCPC

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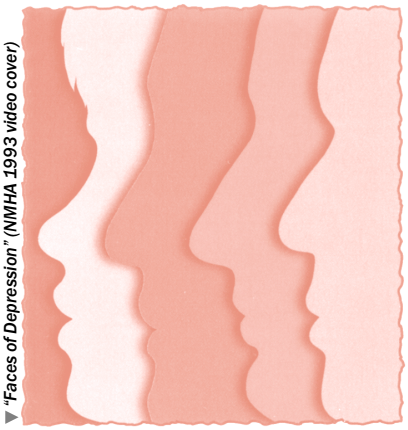
Sarah is a 23-year-old homemaker who feels she can't cope because she is so tired and fatigued. Roger is a 48-year-old truck driver who feels bored with life. Alice is a 41-year-old lawyer who cries and feels suicidal. Maria is a 72-year-old potter with insomnia and disabling headaches.[1] What do all these people have in common? They are all suffering from clinical depression, a medical condition that is often unrecognized and untreated.

Clinical depression, known as major depressive disorder or major depression in medical terms, is the most common mental disorder and one of the most common medical illnesses in the general population. Major depression affects 1 in 7 people at some time in their life. At this moment, 1 in 25 people (4%), or 16,000 people in British Columbia alone, suffer from clinical depression. The chances of having depression are twice as high for women as compared to men. A depressive episode can last from weeks to months (and sometimes, years). The direct medical costs of treating depression in Canada exceed one billion dollars a year.

The social and physical costs of clinical depression are significant. A large study sponsored by the World Bank and the World Health Organization ranked the global burden of all medical diseases according to the combined mortality and disability caused by the disease. In 1990, major depression ranked fourth worldwide in combined disability, outranking heart disease, stroke, and AIDS. In fact, the only conditions that outranked depression were those experienced mainly by Third World countries including infections, diarrhoeal diseases, and perinatal (i.e., before and after childbirth) mortality. This study also estimated that depression will rank second worldwide by the year 2020.



"Faces of Depression" (NMHA 1993 video cover)

The most serious consequences of depression include death by suicide. One person commits suicide in British Columbia each day, and most people who are suicidal are clinically depressed.

Clinical depression can also worsen the outcome of medical conditions. For example, your risk of dying after a heart attack is four times greater if you are clinically depressed. Depression is a greater risk factor for predicting death after heart attack than a history of smoking, previous heart attacks, and poor heart function. (also see page 31).

Symptoms of Depression

Unfortunately, major depression is often unrecognized and untreated even when people are seeing health professionals. In part, this is because many patients present physical symptoms and the depression is missed. Table 1 shows the symptoms experienced by people with major depression. Many people are like Alice in that they feel sad and blue and cry during a depression. Others, like Roger, may not notice depressed mood but will experience lack of interest in usually pleasurable activities. Most patients have physical symptoms like changes in sleep, appetite, and weight. Maria has insomnia and wakens early in the morning, unable to sleep. She also has no appetite and has lost 15 pounds over the past few months. Sarah, however, experiences oversleeping and overeating during her depression along with carbohydrate cravings and weight gain. Some patients feel physically and mentally slowed down, while others feel agitated.

Table 1: Symptoms of Major Depressive Disorder

- DIAGNOSTIC SYMPTOMS
  - ❑ Depressed mood
  - ❑ Loss of interest
  - ❑ Sleep problems (insomnia or oversleeping)
  - ❑ Appetite problems (loss of appetite or overeating)
  - ❑ Feelings of guilt
  - ❑ Low energy
  - ❑ Poor concentration
  - ❑ Psychomotor disturbance (feeling slowed down or agitated)
  - ❑ Thoughts about suicide
- ASSOCIATED SYMPTOMS (symptoms which may accompany depression)
  - ❑ Anxiety
  - ❑ Low self-confidence and self-esteem
  - ❑ Cognitive distortions (negativity, pessimism)
  - ❑ Dependent behaviour
  - ❑ Hallucinations
  - ❑ Delusions
  - ❑ Sensitivity to criticism
  - ❑ Irritability

Feelings of hopelessness, helplessness, and worthlessness are also common when people are depressed. They often think of death and may have thoughts about suicide. There are many myths about suicide that flow through our culture and are still held by some health professionals. One myth is that asking about suicide makes it worse. This is not true. Most people, like Alice, are relieved when they are asked about suicidal thinking and find out that it is a common depressive symptom that can be treated.

Many associated symptoms are found in major depression but are not part of the formal diagnostic criteria. Roger experiences anxiety and has cognitive distortions where his thinking becomes very negative and pessimistic, as if he is seeing

the world through a depressive filter. Alice became indecisive in her court work, and her self-confidence and self-esteem fell. In severe cases, patients may be psychotic, losing touch with reality. They may have hallucinations (perceptual disturbances such as seeing things or hearing voices) or delusions (false fixed beliefs such as feeling responsible for wars going on in the world). Maria was very distressed because she heard voices telling her that she was evil and that she deserved to die.

Diagnosis of Depression

With all these different types of symptoms, it is not surprising that clinical depression is sometimes difficult to recognize. Screening questionnaires such as the Beck Depression Inventory can be helpful. This widely used, self-rated, 21-item scale helps to identify people who may be depressed, but by itself cannot be used to diagnose a clinical depression. Research has shown, however, that two simple questions can be as sensitive as a screening questionnaire: "Have you been feeling sad or depressed?" and "Have you lost interest in your usual activities?" By regularly asking these two questions, many clinicians will be able to identify patients with a clinical depression who might ordinarily be missed.

To make a medical diagnosis of major depression, at least 5 of the 9 major symptoms must be present for at least two weeks. These symptoms must also cause significant distress and/or result in impairment in functioning at work or with relationships. Other medical conditions that can have depressive symptoms (Table 2), prescription medications, and alcohol or substance abuse must be ruled out before making the diagnosis. The normal process of bereavement is also excluded, although extended periods of grief may turn into something meeting the criteria for a major depressive episode.

We classify people with a depressive disorder separately from those with bipolar disorder (formerly called manic-depressive illness). People with bipolar disorder experience manic episodes at some time in their lives in addition to having depressive episodes. During a manic episode, people with this disorder are uncharacteristically euphoric (or irritable), hyperactive, grandiose, and distractible. They speak very rapidly, have racing thoughts, and have less need for sleep. In severe cases, they will also experience psychotic symptoms, sometimes believing they have special powers like telepathy. During the manic episode, they have poor judgment and show impulsive, reckless behaviour such as spending money or getting into needless arguments.

We also differentiate subtypes of depression, including patients with "psychotic" depression (with hallucinations or delusions), "atypical" depression (with overeating, oversleeping, and mood reactivity), and "seasonal" depression (with depressive episodes only in the winter). Distinguishing bipolar disorder and these depressive subtypes is important because they have specific and different treatments.

Causes of Depression

The causes of clinical depression are not known, but it is clear that there is a complex interaction between psychological and neurobiological factors. Genetics play a role as clinical depression can run in families, and the chance of having a clinical depression is increased if a family member also has the condition. However, it is not yet possible to predict who in the family will develop depression. Many studies show biological changes in the brains of people with clinical depression, especially in neurotransmitters, the chemicals involved in transmitting signals between neurons. Disturbances are found with serotonin, noradrenaline, and dopamine, the main neurotransmitters regulating mood and emotion. There are also many hormonal abnormalities and disturbances in the biological function of sleep and circadian rhythms (the daily rhythms generated by the biological clock in the brain).

There is also much evidence that psychosocial factors are important. Early parental loss, social isolation, personality style, and stressful life events can all increase the risk of developing a clinical depression. For example, Roger began to be depressed after a recent separation from his wife, while Sarah is struggling with marital and parenting stress.

Unfortunately, for an individual person, it is not usually possible to identify a single cause of depression. However, it is still important to identify biological, psychological, and social factors that may be contributing to the clinical depression because specific treatments can be targeted in each of those domains. For example, antidepressants can be used for biological factors, psychotherapeutic approaches can be used for psychological factors, and occupational or marital therapy can address social factors. Later on in the issue, we'll return to the stories of Sarah, Roger, and Maria, and look at the treatment alternatives that they've found helpful. (see page 16) ■

Footnote

1 All names and case histories are fictitious and represent an amalgamation of patient stories.

Table 2: Some Medical Conditions with Depressive Symptoms

- NEUROLOGICAL
  - ❑ Alzheimer's disease / other dementias
  - ❑ Huntington's disease
  - ❑ Migraine headaches
  - ❑ Multiple Sclerosis
  - ❑ Parkinson's disease
  - ❑ Stroke
- CANCERS
  - ❑ Brain
  - ❑ Pancreas
- INFLAMMATORY
  - ❑ Irritable Bowel Syndrome
  - ❑ Systemic Lupus Erythematosis
- CARDIOVASCULAR
  - ❑ Heart failure
  - ❑ Myocardial infarction (heart attack)
- METABOLIC AND ENDOCRINE
  - ❑ B_{12} or iron deficiency
  - ❑ Cushing's Syndrome
  - ❑ Diabetes
  - ❑ Hypocalcemia
  - ❑ Hypo/Hyperthyroidism
  - ❑ Uremia
- OTHER
  - ❑ AIDS/HIV
  - ❑ Chronic Fatigue Syndrome
  - ❑ Chronic pain
  - ❑ Fibromyalgia

In this section, we examine some of the alternatives and approaches that have helped people with mood disorders return to a normal life. After looking at an overview of some of the most prominent approaches, we'll take a closer look at the closely related approaches of cognitive behavioural therapy (sometimes simply known as "cognitive therapy") and psychoeducation, and then highlight the efforts being made by people with mood disorders to educate themselves, through the internet, and within the self-help movement. Then we'll focus in on emerging approaches, in particular on early intervention and prevention of mood disorders in youth and adults.

Treatment of Depression

Raymond W. Lam, MD, FRCPC

(This article is continued from page 5 although it can be read on its own).

Major depression is one of the most treatable conditions in medicine and there are many effective treatments available. Unfortunately, many clinically depressed people never get treated. There is still stigma attached to having a mental disorder that prevents many people from seeking help. Sometimes they do not recognize that their symptoms are treatable, and sometimes their depression is unrecognized by health professionals. An Ontario study found that 90% of clinically depressed people had seen a family physician within the previous few months, but only 50% received treatment for their depression. The other 50% were untreated; of these, half declined treatment due to stigma and the other half were "living with it." Even for the people receiving treatment, only a minority was receiving effective treatment for depression.

The objectives of treatment for depressive disorder are: 1) to reduce and remove the physical and psychological symptoms of depression, 2) to restore role function, and 3) to prevent relapse and recurrence of depression. In the past 20 years, a number of proven effective treatments have been studied. These include new antidepressant medications, specific focused psychotherapies such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), electroconvulsive therapy (ECT), and light therapy.

Antidepressants

Antidepressant medications have been used for over 50 years and there are over 20 antidepressants currently available. The newer medications (the Selective Serotonin Reuptake Inhibitors, starting with Prozac in 1988) specifically affect different neurotransmitters in the brain. Not only are they as effective as the older medications, they are safer and have far fewer side effects. Unfortunately, there is no particular symptom or blood test that allows us to determine which antidepressant is best for an individual patient. The choice of an antidepressant is often based on the side effects that may occur. Regardless, about 75% of people improve when they take antidepressants for clinical depression. For instance, Alice, the lawyer we met earlier in this issue of *Visions*, was initially concerned about taking medications, but after using an antidepressant for a couple weeks, started feeling better. After two months, she was feeling almost back to her usual self and able to return to full-time work.

People are often uncertain about taking medications for their depression. They may discontinue the medications before they experience any benefits because they have unfounded negative beliefs about antidepressants. Five simple messages from the clinician to address some of these mistaken beliefs have been shown to greatly improve compliance to antidepressant medications (see Table 1 below).

Psychotherapies

Psychotherapies are also effective for treating clinical depression. There are many different types of psychotherapy, but the best validated treatments are "short-term" psychotherapies consisting of 12 to 16 sessions, once or twice a week. Several studies have shown that these psychotherapies are as effective as medications for some types of depression. Combination antidepressant and psychotherapy treatment may be most beneficial for people who are not responding to one or the other. Unfortunately, there is still limited access to these validated psychotherapies in the community.

Cognitive behavioural therapy (CBT) is based on the recognition that depressed people have negative thoughts and pessimistic thinking patterns that contribute to their depression. They may dwell on the negative aspects and discount the positive aspects of a situation, and will "catastrophize" when trying to problem-solve. These "cognitive distortions" result in learned maladaptive behaviours. In CBT, the depressed person learns to identify and test these negative cognitions and learns practical strategies to break the negative cycle. CBT involves keeping track of mood states and doing homework assignments to practice what is learned during the sessions. When Roger underwent CBT and learned to reverse his negative thinking pattern, his mood improved and he became more socially active.

Interpersonal psychotherapy (IPT) is based on the recognition that depression is associated with significant relationship problems that either predate and contribute to the illness, or that are consequences of having a

Table 1: Five Messages to Improve Antidepressant Compliance

1. Take the medications daily
2. The medications are not addictive
3. Antidepressants do not work immediately, and it may take two to four weeks before you start feeling better
4. Do not stop taking your medications without checking with your doctor, even when you feel better
5. Mild side effects are common, especially at the beginning of treatment, and will usually improve once your body gets used to the medication

clinical depression. IPT starts with a detailed assessment of current and past relationships and then focuses on the most pressing problem such as unresolved grief, social role disputes, social role transitions, or social isolation. Practical strategies are then learned to deal with the problem relationship. Sarah found that IPT helped her to focus on her marital issues and family roles. Once these were addressed, her depression improved.

Some depressed patients improve with antidepressants, others improve with psychotherapy, and still others need a combination of treatments to show most benefit. Again, we cannot yet predict who will do best with which treatment, and in some cases it is a matter of personal preference whether to take medications or to undergo psychotherapy.

Other Biological Treatments

There are, however, people with severe or difficult-to-treat illnesses who clearly require biological treatments. For some of these patients, electroconvulsive therapy (ECT) is often the best treatment. Contrary to the usual negative public perception of "shock therapy," modern ECT is a very safe and effective treatment for clinical depression. During ECT, an electrical stimulus is administered to produce a seizure in the brain lasting 60 to 90 seconds. A general anesthetic and muscle relaxants are used so patients are asleep, and there is no muscle response during the seizure. Patients are carefully monitored during the procedure and usually require about eight treatments over the course of three or four weeks. There are some side effects associated with ECT, in particular a temporary short-term memory disturbance for around the time when patients are getting ECT. Studies using detailed neuropsychological tests found that six months after a course of ECT, there were no intellectual or memory differences between those depressed people who received ECT and those who did not.

This procedure can be a life-saving treatment for patients who are severely suicidal or who have severe symptoms like psychosis. For example, Maria, the 72-year-old woman who was having hallucinations during her depression and was at high risk of suicide, recovered completely after receiving a course of ECT. ECT can be effective even when antidepressants have not worked, but it is an expensive treatment because it needs to be done in hospital. We recently reviewed ECT use at UBC Hospital. Of the 130 patients treated over a two-year period, 88% were rated as improved after ECT, compared to only 12% who had little or no improvement. Even though patients were rated only a week after the ECT was completed, only 6% of patients had troublesome memory disturbance.

Light therapy is another biological treatment for people with winter depression, a form of Seasonal Affective Disorder (SAD). Light therapy consists of sitting in front of a bright, fluorescent light box for about 30 minutes a day, usually in the early morning. About two-thirds of patients with SAD respond within a week or two to this simple treatment, although they need to continue light treatment throughout the winter. We don't know exactly how light therapy works, but the two main theories are: 1) that light affects the biological clock in the brain, which may have difficulty adjusting to the changing light levels in the winter, or 2) that light affects neurotransmitters like serotonin.

In summary, major depression is a very common illness in the general population and health professionals will certainly encounter many patients who are clinically depressed. Sarah, Alice, Roger and Maria illustrate the many faces of clinical depression that makes it challenging to recognize. The causes of major depression are not known but there are likely multiple biological and psychosocial contributing factors. There are many effective biological and psychological treatments for depression, and one can be optimistic that patients with clinical depression can feel better and recover to resume their normal lives. ■

Related Resources

Canadian Network for Mood and Anxiety Treatment (CANMAT) at: www.canmat.org

Depression Information, Education, and Resource Centre (DIRECT) Toll-free Public Line: 1-888-557-5051 (ext. 8000); Physician Line: 1-888-557-5050 (ext. 800) or go to www.fhs.mcmaster.ca/direct

Cognitive Therapy for Depression

Jane E. Brody

Betsy Jacobson of Brewster, NY, had grappled with the crippling effects of depression and a deflated ego almost her entire life. Reared in a domineering family with a controlling father, she was unable to fulfill her ambitions and use her talents as an actress. "I was scheduled to fail at everything I did," she recalled in an interview. Years of psychotherapy, including analysis, did nothing to ease her psychic pain — nothing, that is, until she began seeing a cognitive therapist. Cognitive therapy helps to improve people's moods and behaviour by changing their faulty thinking, how they interpret events, and talk to themselves. It guides them into thinking more accurately and realistically and teaches them coping strategies to deal with problems.

"He saved my life," Mrs. Jacobson said emphatically of her cognitive therapist. "At age 52, I was suddenly able to grow an ego. The difference in the therapeutic approach was dramatic, and the relief I felt was immediate. Instead of dwelling on the negative, which the other therapists did, and which only ground my ego further into the ground, the cognitive therapist treated me like a decent, respectable human being with valid feelings. A healthy sense of myself was drummed into my head while I learned how to change my thoughts and feelings."

"In midlife, I finally became a free woman, a person with self-respect," she continued. "I could start a brand-new life and do