Dealing with Depression

Edited by Justin Healey

ISSUES IN SOCIETY

THE SPINNEY PRESS
# CONTENTS

## CHAPTER 1  
**UNDERSTANDING DEPRESSION**

Depression: an overview 1  
Depression’s many shades of blue 4  
Facts and figures about mental health and mood disorders 6  
Mental and behavioural conditions 7  
Causes of depression 9  
Feeling down: when does a mood become a disorder? 11  
Understanding depression 13  
Myths about depression 16  
Mental health stigma still affecting Australian workers with research showing 4 in 10 hide depression from employers 18  
Helping a friend with depression 20  
Depression in adolescents and young people 21  
Young people, feelings and depression 23

## CHAPTER 2  
**DIAGNOSIS, TREATMENT AND MANAGEMENT**

Depression: Q&As 27  
Depression diagnosis 30  
Depression self-test 31  
Depression – treatment and management 32  
Treatment for depression 35  
Antidepressant medicines 37  
Types of antidepressants 38  
Are antidepressants over-prescribed in Australia? 40  
Psychological interventions for depression 42  
Talking therapies can harm too – here’s what to look out for 44  
Self-help and alternate therapies 46  
The treatment of depression in young people 48  
Exploring issues – worksheets and activities 51  
Fast facts 57  
Glossary 58  
Web links 59  
Index 60
Dealing with Depression is Volume 392 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
Are you, or someone you know, experiencing low moods? One in five women and one in eight men will experience depression at some time in their life. Depression is often not recognised and can persist for months or even years if left untreated.

Depression is treatable and effective treatments are available. Dealing with depression early can help you address problems quickly and avoid symptoms becoming worse. So what are the signs and symptoms of depression? This book examines the myths and explains the facts in relation to the major types of depression, and offers helpful general advice on diagnosis, treatment and management from trusted mental health organisations. Learn to find ways to beat the blues and deal with depression.

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:
- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
DEPRESSION: AN OVERVIEW

Better Health Channel explains a range of depression-related issues with this fact sheet information.

Everyone feels sad sometimes, particularly when faced with loss or grief, but depression is more than low mood and sadness at a loss. It is a serious medical condition. It is the result of chemical imbalances in the brain. A person with depression feels extremely sad, dejected and unmotivated.

DEPRESSION IS COMMON

One in five women and one in eight men will experience depression at some time in their life. The good news is that just like a physical illness, depression is treatable and effective treatments are available.

SYMPTOMS OF DEPRESSION

You may have depression if, for more than two weeks, you have felt sad, down or miserable most of the time, or have lost interest or pleasure in most of your usual activities, and if you have also experienced several of the symptoms across at least three of the groups of symptoms below.

Remember that everyone experiences some of these symptoms from time to time – it may not necessarily mean you are depressed. Equally, not every person who is experiencing depression will have all of these symptoms.

Behavioural symptoms of depression

A person with depression may:
• Have stopped going out
• Not be getting things done at work or school
• Be withdrawing from close family and friends
• Be relying on alcohol and sedatives
• Have stopped their usual enjoyable activities
• Be unable to concentrate.

Thoughts caused by depression

A person with depression may have thoughts such as:
• ‘I’m a failure.’
• ‘It’s my fault.’
• ‘Nothing good ever happens to me.’
• ‘I’m worthless.’
• ‘Life’s not worth living.’
• ‘People would be better off without me.’

Feelings caused by depression

A person with depression may feel:
• Overwhelmed
• Guilty
• Irritable
• Frustrated
• Lacking in confidence
• Unhappy
• Indecisive
• Disappointed
• Miserable
• Sad.

Physical symptoms of depression

A person with depression may experience:
• Fatigue
• Feeling sick and ‘run down’
• Headaches and muscle pains
• Churning gut
• Sleep problems
• Loss or change of appetite
• Significant weight loss or gain.

CAUSES OF DEPRESSION

Generally, depression does not result from a single event, but from a mix of recent events and other longer-term or personal factors, which cause chemical imbalances in the brain. These factors might include...
life events, family history, personality, serious medical illness, and drug and alcohol use.

You can’t always identify the cause of depression or change difficult circumstances. The most important thing is to recognise the symptoms and seek help.

**Life events and depression**

Continuing difficulties – such as long-term unemployment, living in an abusive or uncaring relationship, long-term isolation or loneliness, or prolonged stress at work – are more likely to cause depression than recent life stresses. However, recent events (such as losing a job) or a combination of events can trigger depression in people who are already at risk because of past bad experiences or personal factors.

**Family history and depression**

Depression can run in families, but this doesn’t mean a person will automatically experience depression if a close relative has had the illness. Other factors are still important.

**Personality and depression**

Some people may be more at risk because of their personality, particularly if they tend to worry a lot, have low self-esteem, are perfectionists, are sensitive to personal criticism, or are self-critical and negative.

**Serious medical illness and depression**

Serious illnesses can bring about depression directly or can contribute to depression through the associated stress and worry, especially if it involves long-term management of illness or chronic pain.

**Drug and alcohol use and depression**

Drug and alcohol use can lead to and result from depression. Many people with depression also have drug and alcohol problems.

**Changes in the brain and depression**

We do not fully understand what happens in a person’s brain to cause depression. Depression may be related to changes in certain chemicals that carry messages within the brain – particularly serotonin, norepinephrine and dopamine, the three main chemicals related to mood and motivation. Changes to stress-hormone levels may also play a part.

Research suggests that behaviour can affect brain chemistry – for example, long-term stress may cause changes in the brain that can lead to depression. Changes in brain chemistry have been more commonly associated with severe depression than with mild or moderate depression.

**SEEK HELP FOR SYMPTOMS OF DEPRESSION**

If you experience some or most of the symptoms of depression, seek advice from a doctor or counsellor. Don’t delay. Tackling depression early can help you address problems quickly and stop symptoms becoming worse.

Depression is often not recognised and can go on for months or even years if left untreated. A range of treatments, health professionals and services is available, and there are many things that people can do to help themselves. Different types of depression require different treatment.

**TYPES OF DEPRESSION**

Different types of depression often have slightly different symptoms.

The main types of depression include:

- Major depressive disorder
- Bipolar disorder (used to be called ‘manic depression’)
- Cyclothymic disorder
- Dysthymia
- Seasonal affective disorder (SAD).

**Major depression**

Sometimes, this is called major depressive disorder, clinical depression, unipolar depression or simply depression.

Symptoms can include:

- Low mood
- Loss of interest and pleasure in usual activities
- Significant sleep disturbance
- Loss of appetite
- Unexpected weight loss
- Loss of energy
- Feelings of guilt or worthlessness
- Suicidal thoughts.

A person with major depression will experience symptoms nearly every day for at least two weeks. Changes in lifestyle and attitude do not help. The symptoms interfere with all areas of a person’s life, including work and social relationships.

Major depression requires immediate professional help – it is a serious medical condition.
**Melancholia**

The term ‘melancholia’ describes a severe form of depression involving many of the physical symptoms of depression. For example, the person moves more slowly and is more likely to have depressed mood characterised by complete loss of pleasure in everything or almost everything.

**Psychotic depression**

Sometimes, people with a depressive disorder can lose touch with reality. Psychosis can involve hallucinations (seeing or hearing things that are not there) or delusions (false beliefs that are not shared by other people). A person with psychotic depression may believe they are bad or evil, being watched or followed, or that everyone is against them (paranoia), or that they are the cause of illness or bad events occurring around them.

**Antenatal and postnatal depression**

Women are at higher risk of depression during pregnancy and in the year following childbirth. The causes of depression at this time can be complex. In the days immediately following birth, up to 80 per cent of women experience the ‘baby blues’ – a common condition related to hormonal changes – but this is different from depression.

Depression is longer-lasting and can affect not only the mother, but her relationship with her baby, the child’s development, the mother’s relationship with her partner and other members of the family. Up to one in 10 women will experience depression during pregnancy. This increases to one in seven in the first three months after having a baby.

**Bipolar disorder**

Bipolar disorder used to be called ‘manic depression’ because the person experiences periods of depression and periods of mania. In between, there are periods of normal mood. Mania is like the opposite of depression and can vary in intensity – symptoms include feeling great, having plenty of energy, racing thoughts, little need for sleep, talking fast, having difficulty focusing on tasks, and feeling frustrated and irritable. This is not just a fleeting experience.

Sometimes, the person loses touch with reality and has episodes of psychosis. This involves hallucinations or delusions. Bipolar disorder seems to be most closely linked to family history. Stress and conflict can trigger episodes for people with this condition.

**Cyclothymic disorder**

Cyclothymic disorder is often described as a milder form of bipolar disorder. The person experiences chronic fluctuating moods over at least two years, involving periods of hypomania (a mild to moderate level of mania) and periods of depressive symptoms – with very short periods (no more than two months) of normality between. The symptoms last for a shorter period of time, are less severe, and not as regular as those of bipolar disorder or major depression.

**Dysthymia**

Dysthymia (or dysthmic disorder) has symptoms similar to major depression, but less severe. However, symptoms of dysthymia last longer than those of major depression. A person has to have this milder form of depression for more than two years to be diagnosed with dysthymia.

**Seasonal affective disorder (SAD)**

SAD is a mood disorder that has a seasonal pattern. The cause is unclear, but may be related to the variation in light exposure in different seasons. SAD is characterised by mood disturbances (either periods of depression or mania) that begin and end in a particular season. Depression in winter only is the most common.

SAD is usually diagnosed after the person has had the same symptoms during winter for two or more years. People with SAD are more likely to experience lack of energy, sleep too much, overeat, gain weight and crave carbohydrates. SAD is rare in Australia, and more likely to be found in places with short winter days such as Scandinavia.

**Where to get help**

- Your doctor
- Local community health centre
- beyondblue support service, Tel: 1300 224 636
- Lifeline, Tel: 13 11 14
- Kids Helpline, Tel: 1800 55 1800
- SuicideLine, Tel: 1300 651 251
- SANE Mental Health Information Line, Tel: 1800 187 263 Monday to Friday, 9am to 5pm
- Australian Psychological Society – Find a psychologist service, Tel: 1800 333 497
- AREFEMI (Association of Relatives and Friends of the Emotionally and Mentally Ill), Tel: (03) 9810 9300.

**Things to remember**

- Depression is a constant feeling of dejection and loss, which stops you doing your normal activities.
- Different types of depression exist, with symptoms ranging from relatively minor (but disabling) to very severe.
- Generally, depression does not result from a single event, but from a mix of events and factors, which cause chemical imbalances in the brain.
- If you feel depressed, see your doctor for an assessment. Don’t delay. Tackle depression early to address problems quickly and stop symptoms becoming worse.

This fact sheet was produced in consultation with and approved by beyondblue.
DEPRESSION’S MANY SHADES OF BLUE

Depression comes in many different forms of severity, symptoms and causes, writes Bianca Nogrady in this fact file for ABC Health & Wellbeing.

Understanding the different types of depression is essential to ensuring those with symptoms get the treatment they need, many experts argue.

When it comes to depression there is no single, one-size-fits-all entity. It comes in many different shades of severity, of symptoms and of causes.

As a result many psychiatrists now argue that it is helpful to understand major depression not as a single condition, but as different subtypes. Not only do these subtypes and disorders vary in terms of the symptoms, but also in how they respond to different treatments.

Non-melancholic depression

Non-melancholic depression refers to depression that is primarily psychological, rather than biological. It is sometimes called ‘reactive’ depression because it develops in response to a stressful life event, such as the death of a loved one, divorce or job loss, or ongoing stressors that have a negative effect on someone’s self-esteem. It can also come about as a result of an individual’s personality type.

Of those people who go to their doctor with depression, 90 per cent of cases fit into this category.

While non-melancholic depression is common, it can also be difficult to diagnose because it doesn’t generally have the same distinguishing features that characterise other forms of depression, such as extreme lethargy or delusions.

The main features of non-melancholic depression are:

• A depressed mood for more than two weeks
• Social impairment; for example, difficulty functioning normally at work or in relationships.

On the positive side, people with non-melancholic depression often get better by themselves over time. This type of depression also tends to respond well to treatment, particularly psychological treatments such as psychotherapy or counselling, that can help individuals deal with the stressors that may have triggered the depression in the first place.

Melancholic depression

Melancholic depression is less common and affects between 2 and 10 per cent of people who have been diagnosed with depression; but it tends to be more severe than non-melancholic depression, affecting not only mood but also physical function.

People with melancholic depression often have:

• Extremely depressed mood
• Difficulty being cheered up
• An inability to find pleasure in anything
• Extreme lethargy – tend to move more slowly
• Low energy
• Poor concentration
• More agitated movements (sometimes).

Melancholic depression rarely gets better by itself and doesn’t tend to respond well to psychological therapies as a first step. Melancholic depression is best treated with drugs, such as antidepressants, which can help to correct the underlying imbalance of neurotransmitters – the brain’s chemical messengers – such as serotonin, dopamine and noradrenaline.

When the depression starts to abate, psychological interventions...
can play an important role in getting a person back to full functioning.

**Psychotic depression**

Psychotic depression is the rarest of the depression subtypes. People with psychotic depression tend to have a more severe depressed mood than melancholic and non-melancholic depression, and more severe psychomotor disturbances, such as lethargy, poor concentration and slowed or agitated movements.

On top of that, psychotic depression’s most defining characteristics are psychotic symptoms such as hallucinations (seeing things or feeling sensations that aren’t real), delusions (false beliefs) and paranoia (believing that people are conspiring against them or that they themselves are the cause of bad things happening around them).

Psychotic depression will not get better by itself and only responds to treatment with medicines such as antipsychotics and antidepressants.

**Antenatal/postnatal depression**

Having a new baby can be extremely stressful, particularly in the first year as the usual day-to-day challenges of life are compounded by lack of sleep, the general chaos associated with a new baby, and hormonal changes.

However, for some women, the so-called ‘baby blues’ persist for much longer or are more severe, affecting not only the mother but also her relationship and interactions with her baby, partner and family. This then becomes known as postnatal depression. If the depression affects a mother during, rather than after pregnancy, it is called ‘antenatal depression’.

Around 10 per cent of women will experience antenatal depression, but even more – around 16 per cent – will experience depression in the first year after their child’s birth.

**Bipolar disorder**

Once known as ‘manic depression’, bipolar disorder features both depression and periods of mania interspersed with periods of normal functioning. It’s thought to affect around 2 per cent of the population.

The mania or hypomania of bipolar disorder can take a variety of forms. Individuals may actually feel really good during periods of mania, with lots of energy, racing thoughts, little need for sleep and fast talking. However, they may also be easily frustrated and irritable and having difficulty focusing on tasks.

Sometimes people with mania experience features of psychosis, such as hallucinations and delusions, e.g. believing they have superpowers.

Bipolar disorder 1 is the more severe disorder in terms of symptoms, and those with the condition are more likely to experience mania, have longer ‘highs’, be more likely to have psychotic experiences and be more likely to be hospitalised.

Bipolar disorder II is diagnosed when a person experiences the symptoms of a high but with no psychotic experiences. These hypomanic episodes can last a few hours or a few days, but research suggest the effects can be as severe as in bipolar I disorder.

While bipolar disorder does appear to run in families, it is often triggered by a stressful event or conflict.

It can be hard to diagnose unless the doctor is aware of the mania or hypomania and because of that, bipolar disorder is often misdiagnosed as depression or schizophrenia, or is blamed on other factors such as drugs or alcohol abuse.

**Seasonal affective disorder**

Seasonal affective disorder, or SAD, is a mood disorder tied to changes in season. Thankfully in sunny Australia, SAD is relatively rare compared to gloomier northern hemisphere climates.

SAD generally follows a pattern of depression – including symptoms of lack of energy, excessive sleeping and eating, weight gain and a craving for carbohydrates – starting at the beginning of winter and lifting at the end of the season. The pattern is repeated for several years.

**Cyclothymic disorder**

Cyclothymic disorder is a milder form of bipolar disorder lasting for at least two years.

Individuals have periods of hypomania, although not as severe as in bipolar disorder, and periods of depression with only short breaks of normal functioning in between.

**Dysthymic disorder**

Dysthymic disorder is essentially a mild but very persistent depression, lasting for more than two years.

**Atypical depression**

This is a form of depression that has the opposite characteristics to major depression.

People with this type of depression still show depressed mood, but they are able to be cheered by happy events; rather than loss of appetite they show increased appetite and weight gain; they tend to sleep excessively, but also experience a heaviness in their limbs.

Individuals with atypical depression tend to be extremely sensitive to rejection and expect that others will dislike or disapprove of them.

If you, or someone you know, needs help, you can call Lifeline 13 11 14, Suicide Callback Service on 1300 659 467, Kids Helpline on 1800 551 800, or MensLine Australia on 1300 789 978.

Bianca Nogrady is a freelance science journalist, broadcaster and author who has published two books, *The End – The Human Experience of Death* and as co-author of *The Sixth Wave: How To Succeed in a Resource Limited World*.

This article was reviewed by Associate Professor Vijaya Manicavasagar, the director of psychological services at the Black Dog Institute.

FACTS AND FIGURES ABOUT MENTAL HEALTH AND MOOD DISORDERS

A fact sheet from the Black Dog Institute, a world leader in the diagnosis, treatment and prevention of mood disorders such as depression and bipolar disorder

GENERAL INFORMATION ABOUT MENTAL ILLNESS IN AUSTRALIA

Mental illness is very common. One in five (20%) Australians aged 16-85 experience a mental illness in any year. The most common mental illnesses are depressive, anxiety and substance use disorder. These three types of mental illnesses often occur in combination. For example, a person with an anxiety disorder could also develop depression, or a person with depression might misuse alcohol or other drugs, in an effort to self-medicate. Of the 20% of Australians with a mental illness in any one year, 11.5% have one disorder and 8.5% have two or more disorders. Almost half (45%) Australians will experience a mental illness in their lifetime.

The onset of mental illness is typically around mid-to-late adolescence and Australian youth (18-24 years old) have the highest prevalence of mental illness than any other age group. Data from the 2014 Mission Australia Youth Survey showed that around one in five (21.2%) of young people (15-19 years old) met the criteria for a probable serious mental illness. Common mental illnesses in Australians are: anxiety disorders (14%), depressive disorders (6%) and substance use disorders (5%).

54% of people with mental illness do not access any treatment. This is worsened by delayed treatment due to serious problems in detection and accurate diagnosis. The proportion of people with mental illness accessing treatment is half that of people with physical disorders.

Access to treatment is essential as approximately 75% of people admitted to public sector mental health inpatient services improve notably. In particular, primary mental health care services are central in addressing signs of mental illness in children and young people with appropriate treatment providing both immediate and long-term positive outcomes.

SUICIDE IN AUSTRALIA

Every day, at least six Australians die from suicide and a further thirty people will attempt to take their own life. While suicide accounts for only a relatively small proportion (1.6%) of all deaths in Australia, it does account for a greater proportion of deaths from all causes within specific age groups. For example, suicide is the leading cause of death for Australians aged 25-44 and the second leading cause of death for young people aged 15-24.

Australians are more likely to die by suicide than skin cancer, yet we know comparatively little about the processes that lead to suicide and how and when to effectively intervene.

Men are at greatest risk of suicide but least likely to seek help. In 2011 men accounted for over three quarters (76%) of deaths from suicide. However, an estimated 72% of males don’t seek help for mental disorders. Other groups that are at greatest risk include: Indigenous Australians, who experience an overall rate of suicide more than double that of non-Indigenous Australians, the LGBTI community, who experience a rate of attempted suicide four times that of those
Mental and behavioural conditions in the Australian Health Survey comprise a range of organic and psychological conditions such as dementia, depression, substance use and anxiety disorders, according to this health profile from the Australian Bureau of Statistics.

In 2011-12 there were 3.0 million Australians (13.6%) who reported having a mental and behavioural condition, an increase from 11.2% in 2007-08 and 9.6% in 2001. Mood (affective) problems, which include depression, were most prevalent (2.1 million people or 9.7% of the population) followed by anxiety-related problems (850,100 people or 3.8%). Mental and behavioural conditions continued to be more common amongst women than men (15.1% compared with 12.0% respectively).

In addition, depression is the number one cause of non-fatal disability in Australia (23%)\(^4\). This means that on average, people with depression live with this disability for a higher number of years than people suffering from other non-fatal diseases such as hearing loss and dementia. The World Health Organisation estimates that depression will be the number one health concern in both the developed and developing nations by 2030\(^{15}\).

**BIPOLAR DISORDER FACTS AND FIGURES**

Bipolar I disorder is when the person experiences oscillating manic (extreme ‘highs’, often with psychotic features) and depressive episodes. The severity and duration of these episodes are often severe and may result in hospitalisation. Bipolar II disorder is when the person experiences oscillating hypomanic (less severe ‘highs’ with no psychotic features) and depressive episodes.

Bipolar I disorder may be experienced by up to 1% Australians over their lifetime (there being no gender difference). The lifetime risk of Bipolar II disorder is up to 5% (with rates higher in women). Early onset of...
bipolar disorder in childhood is rare. The most common risk period is in mid to late adolescence\(^4\).

Amongst people with bipolar disorder, there is typically a 10-20 year interval from first mood episode to diagnosis. During that period of undiagnosed and untreated mood volatility, considerable damage can occur both to the individual and others (e.g. marital break-up). Some people with bipolar disorder are more likely to have significant problems with alcohol and illicit drugs as they try to self-medicate\(^4\).

**MOOD DISORDERS AND GENDER DIFFERENCES**

Mood disorders continue to be more common amongst women than men\(^5\). Rates of depression are slightly higher in women with depression, affecting one in six (17\%) compared to one in ten (10\%) men experiencing depression in their lifetime. Across both subtypes, bipolar disorder affects around one in 33 (3\%) men and women in their lifetime\(^6\). However, prevalence of bipolar disorder is probably higher than the statistics suggest, as many cases are often undetected or misdiagnosed.

Mood disorders are overall more prevalent among males in the 35-44 age group, while for women they are more prevalent in the 25-34 age group, than for other age groups. 7.1\% of women compared to 5.3\% of men, are more likely to report experiencing mood disorders\(^7\).

**PERINATAL DEPRESSION**

Data from the 2010 Australian National Infant Feeding Survey showed that one in five mothers of children aged 24 months or less had been diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child’s first birthday). Further, of all the cases of diagnosed depression, just over one in five were diagnosed for the first time during the perinatal period of the infant selected for the 2010 survey\(^8\).

The majority of mothers suffering from perinatal depression sought treatment from their general practitioner (GP) and support from family and friends. Perinatal depression was more commonly reported among mothers who:

- Were younger (aged under 25)
- Were smokers
- Came from lower income households
- Spoke English at home
- Were overweight or obese
- Had an emergency caesarean section.

Perinatal depression was less commonly reported among mothers who had higher levels of education (bachelor degree or higher), were working at the time of the survey, and primarily spoke a language other than English at home\(^9\).

If you are feeling suicidal contact Lifeline’s 24-hour crisis support service on 13 11 14 or seek immediate help from a GP, psychiatrist or a psychologist.

**REFERENCES**

CAUSES OF DEPRESSION

Causal factors behind depression explained, courtesy of the Black Dog Institute

Introduction

Unlike other illnesses or disorders, there is no simple explanation as to what causes depression. In general, depression can be due to a number of factors including stresses which can range from mild to severe, combined with vulnerability or predisposition to depression that can result from biological, genetic or psychological factors.

Each type of depression is associated with different mixtures of causes. For psychotic or melancholic depression, physical and biological factors are relevant. In contrast, for non-melancholic depression, the role of personality and stressful life events are important.

Genetic factors

There is strong evidence that genetic factors play a significant role in a person’s predisposition towards developing depression, especially melancholic depression, psychotic depression and bipolar disorder. No single gene is likely to be responsible, but rather a combination of genes.

The predisposition to develop depression can be inherited. The genetic risk of developing clinical depression is about 40% if a biological parent has been diagnosed with the illness, with the remaining 60% being due to factors within the individual’s own environment. Depression is unlikely to occur without stressful life events, but the risk of developing depression as a result of such an event is strongly genetically determined.

Biochemical factors

Our knowledge of the human brain is still fairly limited, therefore we do not really know what actually happens in the brain to cause depression.

It is likely that with most instances of clinical depression, neurotransmitter function is disrupted. Neurotransmitters are chemicals that carry signals from one part of the brain to the next. There are many neurotransmitters serving different purposes. However, three important ones that affect a person’s mood are serotonin, noradrenaline and dopamine.

In normal brain function, neurotransmitters interact with a series of nerve cells, with the signal being as strong in the second and subsequent cells as it was in the first. However, in people who are depressed, mood regulating neurotransmitters fail to function normally, so that the signal is either depleted or disrupted before passing to the next nerve cell.

Physical illness

In a simple sense, physical illness can lead to depression through the lowered mood that we can all experience when we are unwell, in pain or discomfort, confined and less able to do the things we enjoy.

Illness can also change the body’s functioning in a way that leads to depression. Even if the illness isn’t making us feel down we can still suffer from depression.

For example:

• It is known that certain cancers can produce a depressive illness – in these cases a person might be quite unaware that they are suffering from depression
• Compromised immune functioning might play a part in the emergence of depression, although further research is needed to establish this link.

The ageing brain

As we age, our brain’s general functioning can become compromised and this can affect the neurotransmitter pathways which influence mood state.

Three reasons for these changes...
are worth mentioning in relation to depression:

• Late onset depression: Elderly people who develop dementia may also develop a severe depression for the first time; this type of depression is commonly of a psychotic or melancholic type and reflects the disruption of circuits linking certain basal ganglia and frontal regions of the brain.

• These brain changes can reflect an ageing process, particularly in people who are vulnerable to this kind of ‘wear and tear’.

• In others however, high blood pressure or mini-strokes (often unnoticed by the individual and their family) may contribute. Good blood pressure control can reduce the chance of depression in some people with this problem.

Gender

Gender is a partial but incomplete explanation of why people may develop depression. Equal numbers of men and women develop melancholic depression. However, studies have shown that there is a much greater likelihood of women developing non-melancholic depression than men.

Some explanations for this are:

• Women are more likely than men to ‘internalise’ stress, thereby putting them at greater risk of developing depression.

• Women with unsatisfactory marriages or who are caring for a number of young children are also highly over represented among samples of depressed people.

• Hormonal factors commencing in puberty may account for the increased chance in women of developing anxiety (a precursor to depression) or depression.

Stress

It is important to recognise that nearly every individual can be stressed and depressed by certain events. Most people get over the stress or depression within days or weeks while others do not.

Ways that stress can lead to depression include the following:

• Past or longstanding stresses can increase the chances of an individual developing depression in later years e.g. growing up in an abusive or uncaring family may increase the risk of developing depression in adult life.

• Events that affect a person’s self-esteem such as the break-up of a close relationship or marriage.

• Feelings of ‘shame’ for example, thinking they have not lived up to their own or others’ expectations.

Key points to remember

• There is no single cause for depression; rather it’s a combination of stress and a person’s vulnerability to developing depression.

• The predisposition to developing depression can be inherited.

• Other biological causes for depression can include physical illness, the process of ageing and gender.

• Stress can trigger depression but understanding its particular meaning to the person is important.

• Certain temperament and personality styles pose risks for developing non-melancholic depression.

Each type of depression is associated with different mixtures of causes. For psychotic or melancholic depression, physical and biological factors are relevant. In contrast, for non-melancholic depression, the role of personality and stressful life events are important.
FEELING DOWN: WHEN DOES A MOOD BECOME A DISORDER?

We’ve all felt sad, anxious or down at one time or another, but where does the normal experience of emotion end and the clinical picture of a mood or anxiety disorder begin? Gordon Parker and Amelia Paterson explain in this article from The Conversation

Psychiatry has two widely used classificatory systems that provide definitions of ‘clinical’ states of such emotions as differentiated from ‘normal’ states – the World Health Organisation’s International Classification of Diseases and the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM).

The boundaries are not absolute and, in recent decades, the DSM in particular has been criticised for expanding the boundary of clinical states into essentially normal domains.

Although severity is an important thing to consider in depression, we prefer to distinguish by depression type, not just severity. Depressive disorders can be divided into two types – melancholic and non-melancholic conditions.

DEGREES OF DEPRESSION

Clinical depression is distinguished in such diagnostic manuals by a number of parameters including severity, duration, persistence and recurrence.

More severe depressive disorders are accompanied by the individual experiencing gravid depressive symptoms (such as suicidal preoccupations), by distinct impairment (such that it prevents them from going to work) and lasting more than two weeks.

Although severity is an important thing to consider in depression, we prefer to distinguish by depression type, not just severity. Depressive disorders can be divided into two types – melancholic and non-melancholic conditions.

The latter is a diverse group that could reflect the contribution of severe life events, such as being humiliated by a partner or a personality style that predisposes someone to depression.

Such personality styles include being an anxious worrier, sensitive to judgement by others, being a perfectionist, having intrinsically low self-esteem, being profoundly shy or having a low sense of self-worth since childhood.

In contrast, melancholic depression is better positioned as a disease, having rather specific clinical features, a strong genetic contribution, biological underpinnings and responding only partially to counselling or psych-otherapy but well to antidepressant drugs.

During melancholic depressive states, the individual lacks energy, experiences little pleasure in life, is physically slowed down, and tends to feel much worse in the morning.

Extremely severe melancholic depression may even include psychosis, though importantly this is normally very responsive to appropriate medical treatment.

BIPOLAR DISORDERS

The bipolar disorders are also better positioned as ‘diseases’. We now distinguish bipolar I (previously manic depressive illness) and bipolar II conditions – by the extremity of the highs.

While both bipolar I and bipolar II are characterised by swings from high to low moods, in bipolar I the highs (mania) are more extreme and can include psychosis or hospitalisation.

The bipolar disorders are also better positioned as ‘diseases’. We now distinguish bipolar I (previously manic depressive illness) and bipolar II conditions – by the extremity of the highs.

Highs (hypomania) in bipolar II are less extreme and will never include psychosis or a need for hospitalisation. While it’s normal for everyone to experience periods of happiness in their life, the highs experienced in bipolar are distinctly different.

The individual loses day-to-day anxieties, feels...
Dealing with Depression Issues in Society | Volume 392

First, more people are willing to talk about their experiences, as the stigma of these conditions is slowly decreasing. And changes to criteria in diagnostic manuals have effectively classified some ‘normal’ states as clinical conditions.

But being diagnosed with a mood or anxiety disorder can be a stressful experience itself. The reaction generally depends on how well the person relates to the diagnosis, whether or not the diagnosis was something anticipated and whether or not they expect a diagnosis and adequate treatment will improve their life.

**ANXIETY DISORDERS**

It’s normal for everyone to feel anxious in a variety of situations. Some people might feel anxious going to a party where they don’t know many people, for instance, or giving a speech.

The difference between normal anxiety and an anxiety disorder is when the anxiety is so persistent it stops you doing things you want to, or persists even when all logical reasons to be anxious are absent.

Generalised anxiety disorder, for instance, involves chronic worry without a definitive cause and social phobia involves a fear of talking to or being around others.

**There are many different anxiety disorders, and it can be difficult to distinguish when normal anxiety starts to become a problem.**

The vast majority of conditions can be treated either psychiatrically or psychologically, but finding the right treatment, while ultimately rewarding, can also at times be frustrating.

The vast majority of conditions can be treated either psychiatrically or psychologically, but finding the right treatment, while ultimately rewarding, can also at times be frustrating.

It’s our opinion that Australia is ahead of many other western countries in having destigmatised mood disorders, and the stigma and negative consequences linked to seeking help has reduced considerably.

Unfortunately, this doesn’t mean that stigma is completely eradicated. Some employers may take advantage of knowing that an individual has a psychiatric condition. And the declaration of any condition can prevent people obtaining income protection, and even travel insurance.

But that shouldn’t stop people from seeking help when they feel their emotional health is at risk.

*Gordon Parker is Scientia Professor at UNSW Australia. Amelia Paterson is Research Assistant at UNSW Australia.*

**THE CONVERSATION**

UNDERSTANDING DEPRESSION

What is depression?

Most people experience lows throughout their life. However, we are talking here about a depression that is not just a low mood but a persistent low mood with physical and psychological symptoms.

The expression ‘clinical depression’ describes a group of illnesses that are characterised by an excessive or long-term depressed mood that affects the person’s life. Depression is often associated with anxiety.

Depression is often not recognised and, as a consequence, left untreated.

Depression has been described medically in many ways over time. Recent explanations of reactive (triggered by a stressful event) and endogenous (not seen to have any obvious trigger) are less popular at the moment. It is now more commonly described in terms of severity or degree – a judgement made on a number, type and severity of symptoms present.

Mild depression

Decreases interest in things that were once pleasurable, reduces motivation, and increases irritability. Work or usual life activity is not necessarily interrupted and the depression often goes undiagnosed because it does not cause a crisis which must be attended. People experiencing this degree of depression will often reduce stressful issues in their life to relieve the depression. If ignored however, mild depression may develop further.

Moderate depression

Decreases pleasure in life even further, hence the impact on life is greater. Motivation becomes a real issue and important aspects of life and relationships may be neglected causing further problems and isolation. Untreated at this point, depression can exacerbate into severe depression.

Severe or major depression

Severely interferes with life. A person with this severity of depression will experience low self-esteem, distress, feelings of uselessness, sleep disturbance, appetite change, suicidality, and loss of libido as well as other unique features. In some cases, major depression may develop psychotic features.

What causes depression?

Often there are many interrelated factors associated with depression including inherited disposition, a chemical imbalance in the brain, life stresses, past bad experiences and personality. Medical illness, drugs and alcohol can also play a part.

Treatment and recovery from depression

People experiencing feelings of sadness which have persisted for a long time should firstly contact their family doctor or community health centre. Treatment depends on each person’s symptoms.

The options may include:

- Psychological interventions and general supportive talking therapies so that the person can understand their thoughts and behaviours and sort out practical problems and conflicts
- Antidepressant medications to relieve depressed feelings, restore normal sleep patterns and appetite and reduce anxiety
- Hospitalisation, where safety of the person, monitoring of psychotic symptoms, monitoring of any physical
### INSIGHT INTO THE EXPERIENCE OF DEPRESSION

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>ASSOCIATED BEHAVIOUR</th>
<th>HELPFUL INTERVENTIONS</th>
</tr>
</thead>
</table>
| ▶ Depressed mood, loss of interest or pleasure in nearly all activities | ▶ Characterised by expressions of helplessness and hopelessness  
▶ Depressed most of the day  
▶ Loss of interest or pleasure in activities, and the person may not move much or just stares into space  
▶ Skin may become coarse and dry, and hair limp and greasy or sparse  
▶ Sometimes a person can articulate having no feelings, but a depressed mood can be inferred from the person’s facial expression or demeanour  
▶ Sometimes, depressive mood can be exhibited in irritability rather than sadness, including persistent anger, overreaction to events, angry outbursts and blaming others  
▶ Social withdrawal  
▶ Sometimes a significant reduction from previous levels of sexual interest or desire. | ▶ Be aware you cannot jolly the person out of this state  
▶ Connect with the emotion of the experience rather than try to change someone’s mind e.g. ‘It must be very hard to feel so low’  
▶ Reinforce your love for the person  
▶ Try to sit beside and be in the person’s space — often people who are depressed do not like to make demands on others but they appreciate company. Likewise, you will need to do the talking rather than expecting the person to do so  
▶ Keep up good levels of communication even when not reciprocated e.g. Let the person know where you are going even if there is no response. |
| ▶ Inability to concentrate | ▶ Poor concentration and poverty of thought, where the person has difficulty putting sentences and thoughts together, may give monosyllabic responses and need prompting  
▶ May appear easily distracted or complain of memory difficulties  
▶ A reduction in ability from previous levels to achieve intellectually demanding tasks. | ▶ Attend to safety issues that poor concentration can cause e.g. If someone works with knives or drives  
▶ Set realistic tasks  
▶ Have realistic expectations. |
| ▶ Suicidal ideation | ▶ Recurrent thoughts of death  
▶ May talk about death or suicide  
▶ May attempt suicide. | ▶ Always treat talk of suicide seriously  
▶ Be aware of suicide risk. Ask the appropriate questions and communicate with treating team about this issue. This issue may be a reason for hospitalisation  
▶ If the person expresses unexpected happiness and begins to give possessions away, seek assistance immediately. |
| ▶ Decreased energy, tiredness and fatigue | ▶ A person may report sustained fatigue without physical exertion  
▶ Smallest tasks seem to require substantial effort  
▶ May take twice as long as usual to do things e.g. washing and dressing in the morning. | ▶ Avoid placing unrealistic demands on the person  
▶ Be patient  
▶ Affirm small achievements. |
| ▶ Sense of worthlessness or guilt | ▶ May translate into belief that the person has done something terrible and needs to be punished  
▶ May include unrealistic negative evaluation of self’s worth  
▶ Guilty about preoccupations over minor past failings  
▶ Misinterprets neutral or trivial day-to-day events as evidence of personal defects  
▶ Exaggerated sense of responsibility for untoward events. | ▶ Connect with the emotion of the experience rather than try to change someone’s mind e.g. ‘It must be very hard to feel so low’  
▶ Affirm small achievements  
▶ Avoid too much attempt at problem-solving. The person probably will not be ready  
▶ Avoid long self-effacing, self-defeating talk from the person. |
| ▶ Changes in appetite | ▶ Most commonly reduced appetite  
▶ Sometimes an increase in appetite but usually cravings for particular foods, e.g. sweets or carbohydrates  
▶ Significant loss or gain in weight. | ▶ Be aware of hydration and nutrition issues. Again, these issues may need to be attended to in hospital. |
illnesses and substance use issues and monitoring of medications can be carried out
- For some severe forms of depression, electroconvulsive therapy (ECT) is a safe and effective treatment. It may be life saving for people at a high risk of suicide or who, because of the severity of their illness, have stopped eating and drinking and will die as a result.

**Recovery phase**

The recovery phase involves responding to the broader range of issues that impact on people who are susceptible to depression, including examining actual stress levels and the person's ability to deal with stress. Cognitive Behavioural Therapy (CBT) is the talking therapy of choice for recovery from depression. Being involved in experiences that create a sense of achievement is another important aspect to recovery. Learning new communication techniques can create a sense of achievement and improve relationships. Sometimes medication will need to be ongoing and there may be maintenance doses of ECT administered.

**What can family and friends do to help?**

In addition to the specific interventions previously mentioned, there are many things friends and family can do to help.

Always remember that depression is a medical condition that requires medical treatment. Just as you cannot stop a person's leg bleeding by talking to them, you cannot stop depression without medical intervention. Treatment is effective.

Find out as much about the condition as you can. Knowledge is power and gives you a much better chance of developing good coping strategies.

Be patient. People experiencing depression need to come to some insight regarding their illness. This is not always easy and takes time.

Know what to expect of the mental health system and be prepared to be assertive in seeking appropriate care.

Link in with community organisations that offer supports and services that complement the mental health service system. They often provide educational programs, counselling and local support groups.

Remember to stay healthy yourself. Do not underestimate the impact of the illness on you. Depression often involves trauma and grief and has an impact on whole families. Be prepared to seek support to develop strategies that keep you well.

**Useful references**

- dNet [www.depressionnet.org.au](http://www.depressionnet.org.au)
- Mental Illness Fellowship Victoria [www.mifellowship.org](http://www.mifellowship.org)
- National Alliance on Mental Illness (NAMI) (USA) [www.nami.org](http://www.nami.org)
- Mental Health Australia [www.mhaustralia.org](http://www.mhaustralia.org)
- SANE Australia [www.sane.org](http://www.sane.org)
- beyondblue [www.beyondblue.org.au](http://www.beyondblue.org.au)

Mental Illness Fellowship of Australia fact sheets

- Family and carer supports and services.
- Understanding bipolar disorder.
- Psychiatric medication.
- What can family and friends do to help a person experiencing mental illness?
- Understanding suicide and mental illness.
- Collaborating with professionals.

MYTHS ABOUT DEPRESSION

There are still a few common misunderstandings about what depression is and how it impacts on a person’s life. Read these depression facts from Reachout.com to find out the truth behind the most common myths about depression.

This might help if you …

• Want to know more about depression
• Want to understand what a friend/family member with depression is going through
• Are interested in finding out of the facts about depression.

On the whole, most people are pretty clued in about depression – they know that mental health problems are important, and in most cases, recognise it’s important to get support. But there are still some misunderstandings and myths out there in the community, which make living with depression a lot harder to deal with.

MISUNDERSTANDINGS ABOUT DEPRESSION

On the whole, most people are pretty clued in about depression – they know that mental health problems are important, and in most cases, recognise it’s important to get support. But there are still some misunderstandings and myths out there in the community, which make living with depression a lot harder to deal with.

THE MYTHS

Depression myth 1

All young people get depressed; it’s just a normal part of growing up.

The truth – Everyone feels sad at different times and about different things. Not just young people but people of any age.

Depression is more serious than just feeling sad. It’s when a person feels a sadness which is so severe it interferes with everyday life, and lasts longer than two weeks.

It’s an illness like asthma or diabetes that needs to be treated and managed.

Depression myth 2

If you’re depressed, it just means you’re going through a tough time at the moment.

The truth – Depression isn’t just going through a tough time. Tough times and stressful events – like a relationship breakup or your parents getting a divorce – can lead to depression but they’re not the only cause of depression.

Sometimes depression can have no obvious cause at all but it may be the result of chemical imbalances in the brain.

Depression myth 3

Telling an adult that a friend is depressed is betraying their trust. If someone wants help they’ll get it themselves.
The truth – Depression can really drain a person of energy and it can have a bad impact on their self-esteem. That means a person with depression may not be able to seek help when they need it.

If you’re worried about a friend, encourage them to get help. If they’re not able to do it on their own, you might be able to support them or ask for their permission to talk to a trusted adult about it on their behalf. If they refuse, and you’re still really concerned, you might consider talking to an adult who you trust, such as a teacher, parent or counsellor.

Depression myth 4
All depression needs to be treated with is antidepressants.

The truth – For mild to moderate depression, the first choice of treatment should be psychological therapies. However, if your depression is severe, your doctor might prescribe medication to help you manage your life.

Look for a doctor you feel comfortable with, but keep in mind that it’s quite common to see several doctors before finding one that you like. It’s important that you get along with and trust your doctor, so you can work with him or her to find a treatment plan to keep you well.

Depression myth 5
Just talking and listening to your friends and family will be enough to treat depression.

The truth – Talking and listening to your friends and family is really important to help with the day-to-day ups and downs of life. But like any other illness, depression needs to be managed with professional help. Doctors, counsellors, and psychologists can provide treatments and self-management strategies which your family can’t.

Depression myth 6
People who are depressed need to wake up and get a grip and stop feeling sorry for themselves.

The truth – People don’t choose to be depressed. Depression is an illness that is able to be treated with the right help from health professionals. It’s not something that people can just ‘snap out of’.

What can I do now?
• Find out more info about depression
• See a GP if you’re worried about symptoms
• Learn more about what to do if your friend doesn’t want to seek help.

MENTAL HEALTH STIGMA STILL AFFECTING AUSTRALIAN WORKERS

WITH RESEARCH SHOWING 4 IN 10 HIDE DEPRESSION FROM EMPLOYERS

Four out of 10 Australians who take sick leave for depression keep it hidden from their employer, with almost half fearing their job would be compromised if they revealed their illness. Matthew Grimson reports for ABC News

A SANE Australia study of 1,000 workers found Australians were almost twice as likely not to tell their boss they are suffering depression, compared to their European counterparts.

SANE’s research, which focused exclusively on depression, found Australians on average had taken 14.6 days sick leave for their last depressive episode, compared to the 35.9 days reported by workers in Europe.

Of those who chose not to disclose they were suffering depression, around half felt it was a private issue that was none of their employer’s business.

SANE Australia chief executive Jack Heath says the results suggest stigma surrounding mental health in Australian workplaces is a major problem.

“We know Australians in the workplace with depression don’t feel comfortable raising the issue,” he said.

“In Australia there was a significantly higher level of concern that Australian employers wouldn’t understand the issue and wouldn’t know how to support them.

“What’s interesting is that this seems to be a particular problem in the workplace because when people were asked whether they would disclose their illness to a partner or family friend, we got exactly the same [results] in Australia as we did in Europe.”

SANE and other mental health organisations are holding a national workshop in Sydney today [12 November 2013] to develop recommendations from the study.

Mr Heath says there needs to be a concerted campaign targeting stigma surrounding mental illness in the workplace.

“We’ve been good in increasing awareness – what people would call ‘mental-health literacy’ around depression; we’ve done phenomenal work around that, but we haven’t had the shift in the terms of stigma that we need,” he said.

“You can do things in terms of increasing awareness and understanding, but unless you get those changes in attitude around stigma then you don’t get changes in behaviour.”

Employers obligated to provide ‘psychologically safe workplace’

BeyondBlue chief executive Kate Carnell says the statistics are “very worrying”, but it would be illegal for an employer to sack somebody on the basis of a mental health issue.

Ms Carnell says Australian employers have a legal responsibility to provide a “psychologically safe workplace.”
safe workplace”.

“Employers have an obligation under occupational health and safety legislation to have a mental health friendly workplace,” she said.

“It’s important for workplaces to have mental-health policy in place and also to have leadership – to make it clear to employees that they will treat mental health the same way they treat physical health issues.”

Ms Carnell agrees that stigma in the workplace is still a particular issue.

“What’s important is that workplaces make it clear that we encourage employees to put their hands up early, and if they start to struggle to let their supervisors know and for business to have in place a method to support those people,” she said.

“Stigma is still a real issue – we are getting better as a community but we are not there yet.

“[We] need to focus on reducing that stigma, but particularly in the workplace.”

Ms Carnell says reducing mental illness issues in the workplace will not only benefit workers, but is essential to boosting productivity in Australia.

“If you can support [workers] early then there is a good chance they won’t end up having to have time off, which is of course a cost to the workplace and the employee as well,” she said.

“The cost to Australian workplaces now exceeds $12 billion. Last year, stress-related work compensation issues topped $10 billion, so mental-health issues are costing Australian businesses significant dollars.

“We need to make it clear to employers that having a mental-health safe workplace is not only the law, but it will also help increase productivity, achieve their bottom line, reduce staff turnover and absenteeism, so everybody is a winner.”

The National Mental Health Commission has convened The Mentally Healthy Safe Workplace Alliance, which launched a national campaign in January [2014].

beyondblue estimates that 3 million Australians are currently living with depression or anxiety.

Reproduced by permission of the Australian Broadcasting Corporation and ABC Online. © 2014 ABC. All rights reserved.

HELPING A FRIEND WITH DEPRESSION

Know someone going through depression but not sure what to do? Find out why support from friends and family is really important, and check out the tips for helping someone through depression. Don’t forget to look after yourself too. Advice from ReachOut.com

This can help with ...

• Reducing your stress levels
• Knowing how to talk to someone about depression
• Knowing when to get professional help.

Why it helps

While everyone’s experience is different, going through depression can be a pretty intense experience – so having support from friends and family can be really important. If someone you know is going through depression, check out these tips on how to help them through the tough times.

How to help someone with depression

• Be there to listen. Make conversations about what they’re going through easy and open. Ask them what you can do – find out what they find helpful during tough times. Make sure you acknowledge they are feeling down but try and remain positive and encouraging.
• Choose when to talk. If you want to bring up a sensitive issue with someone, try and choose a time when you are both relaxed. Avoid talking to them during an argument or if they are upset.
• Accept their condition. If someone is suffering from symptoms of depression, it isn’t possible for them to just snap out of it, cheer up, or forget about it. Asking them to do this can come across like you’re not taking their feelings seriously and could upset them.
• Get informed. Finding out more info about depression might help you better understand what someone is going through. Check out the fact sheet on ‘Depression’ at http://au.reachout.com/depression for more info.
• Encourage them to get help. If you have a friend with depression, it’s really important that they seek help. Recommending they go and visit a local doctor/GP is a good first step. You could offer to go with them if they’re worried or need extra support. If they’re not comfortable with speaking to someone face-to-face, there are online and email counselling services.
• Back down if they aren’t ready. If you think a friend needs to visit an expert but they didn’t respond well to the suggestion, don’t force the issue or put too much pressure on them – it could put them off getting help. Remain supportive by offering help and suggestions when asked. The exception to this is if you think someone may be in danger or at risk of hurting themselves or someone else. In this case it’s important that you seek help immediately. Call 000 to reach emergency services and tell someone you trust.

How to help yourself

• Look after yourself. You might be really worried about a friend with depression but it’s really important you also look after yourself by monitoring your own mood and stress levels.
• Don’t give up the things you enjoy. Always make sure you’ve got the time to do your favourite things and work towards your own goals. If you’ve lost sight of your goals, you can always set some new ones.
• Check out some ways to relax. Relaxation is great for helping you unwind and deal with stress.
• Set boundaries. You aren’t going to be able to be there for your friend all the time and you can’t let helping someone take over your life. Set some limits around what you are willing and not willing to do – and make sure you stick to them! For example, you might decide to not take any phone calls in the middle of the night, or to not miss out on any of your own commitments because of your friend.
• Ask for support. It’s important that you’re getting your own emotional support. Talk to people you trust about how you’re feeling. It can be particularly frustrating when you feel like you aren’t able to help someone, so you might also want to go to therapy or join a support group.

Depression in adolescents and young people

This fact sheet from the Black Dog Institute covers signs of depression in adolescence; where to get help for an adolescent; key points to remember; and where to get more information.

INTRODUCTION

One in four young people are living with a mental disorder and 9% of young people (16-24 years old) experience high to very high levels of psychological distress (Australian Institute of Health and Welfare, 2007). People aged 18-24 years have the highest prevalence of mental disorders of any other age group and youth suicide is the leading cause of death in young people aged 15-24 years (ABS, 2012).

Onset of depression is typically around mid-to-late adolescence and it is important to recognise the early warning signs and symptoms. Early intervention can often prevent the development of a severe depressive illness.

DEVELOPMENTAL IMPACT

The teenage years are a time when individuals develop their identity and sense of self. If a depression is left to develop, it can lead to isolation from family and friends, risk-taking behaviours such as reckless driving, inappropriate sexual involvements and drug and alcohol abuse. It can also impact on school performance and study, which can have downstream effects on later career or study options.

Both biological and developmental factors contribute to depression in adolescence. If bipolar disorder or psychosis is suspected, an assessment by a health professional is recommended. See the fact sheet 'Bipolar Disorder in Young People' at www.blackdoginstitute.org.au for more information.

SIGNS OF DEPRESSION IN AN ADOLESCENT

An adolescent who is depressed may not show obvious signs of depression. It is often hard to distinguish adolescent turmoil from depressive illness, especially when the young person is forging new roles within the family and struggling with independence, and having to make academic and career decisions.

Signs of depressed mood include:

- Lowered self-esteem (or self-worth)
- Changes in sleep patterns, that is, insomnia (inability to sleep), hypersomnia (excessive sleep) or broken sleep
- Changes in appetite or weight
- Inability to control emotions such as pessimism, anger, guilt, irritability and anxiety
- Varying emotions throughout the day for example, feeling worse in the morning and better as the day progresses
- Reduced capacity to experience pleasure: inability to enjoy what’s happening now, not looking forward to anything with pleasure such as hobbies

People aged 18-24 years have the highest prevalence of mental disorders of any other age group and youth suicide is the leading cause of death in young people aged 15-24 years.
The teenage years are a time when individuals develop their identity and sense of self. If a depression is left to develop, it can lead to isolation from family and friends, risk-taking behaviours such as reckless driving, inappropriate sexual involvements and drug and alcohol abuse. It can also impact on school performance and study, which can have downstream effects on later career or study options.

or activities
- Reduced pain tolerance: decreased tolerance for minor aches and pains
- Changed sex drive: absent or reduced
- Poor concentration and memory
- Reduced motivation to carry out usual tasks
- Lowered energy levels.

WHERE TO GET HELP FOR AN ADOLESCENT
If you think your son or daughter or someone you are close to, might be depressed, the first step is to either take them to a general practitioner (GP) or to the local Community Health Centre. The GP will either conduct an assessment or refer to a mental health worker who specialises in children and adolescents.

Other initial sources of help are school counsellors and trusted close family members to whom the young person feels comfortable talking.

If the young person does not want to seek help, it is best to explain your concerns and to provide them with some information to read about depression.

There are also some excellent websites designed for young people, as well as confidential online and telephone counselling services.

It’s important for young people to know that depression is a common problem and that there are people who can help.

If there is any mention of suicide this should be taken seriously and immediate help sought from a mental health professional.

KEY POINTS TO REMEMBER
- One in four young people experience a mental disorder with depression being one of the most common problems
- Depression in young people is associated with social withdrawal, drops in performance at school, drug or alcohol use and engaging in risky behaviour
- It can be hard to distinguish depression from adolescent turmoil; if depression is suspected, an assessment should be sought from a GP or other mental health professional
- Immediate help should be sought if a young person talks of suicide.

Young people feel lots of emotions as a normal part of growing up. Learning to cope with negative feelings is an important life skill for young people. Parents can help by being available when their child wants to talk, and helping them work through problems. Don’t leave them to sort things out alone.

Parents worry when their teenager seems upset or angry a lot of the time. It can be hard to know what to do, especially if they don’t talk about what is bothering them.

- Young people feel lots of emotions as a normal part of growing up
- Learning to cope with negative feelings is an important life skill for young people. Being ‘good at feelings’ is more important than feeling happy all the time
- Parents can help by being available when their child wants to talk, and helping them work through problems. Don’t leave them to sort things out alone
- Some young people may be diagnosed with depression.

**DEALING WITH FEELINGS**

Most young people want their negative feelings to stop and to feel happy again.

They may:
- Try to mask their feelings by using drugs or alcohol
- Take risks such as fast driving or unsafe sex
- Withdraw from others
- Engage in self-harm.

Trying to escape bad feelings in these ways often makes things worse.

The best way for young people to deal with negative thoughts and feelings is to ‘open up’ and talk about them and what may be causing them. It will help them avoid emotional problems in the future if they learn to deal with their feelings before an issue becomes a major problem.

**HOW PARENTS CAN HELP**

You can help by not leaving your child to deal with

This e-book is subject to the terms and conditions of a non-exclusive and non-transferable SITE LICENCE AGREEMENT between THE SPINNEY PRESS and: Trinity College, East Perth, library@trinity.wa.edu.au
their situation alone. Be available when they need to talk or need your help to work out an issue e.g. bullying or abuse.

You could also:
- Help them to build networks of supportive relationships. It’s best if they have more than one group of people to talk to e.g. family, school friends, work friends, sport teams, hobby groups
- Notice the good things they do and praise them, as long as this doesn’t make them feel uncomfortable
- Make time to do things with them, one-on-one and as a family
- Avoid family conflict as much as you can
- Help them to deal with problems as they arise rather than let them build up
- Help them to do things you know they enjoy, and to be involved in social and family activities
- Help them to eat well, be active and get plenty of sleep
- Discourage use of alcohol and drugs.

Try not to get angry if they blame you for their problems. Accept that there will be good days and bad days.

It’s not usually helpful to:
- Tell them to deal with their feelings by keeping busy or trying to forget them
- Tell them to ‘snap out of it’ or ‘get their act together’
- Ignore or avoid them
- If you are worried about your child, talking with your doctor is a good place to start.

Talking with your child
Some young people find it hard to talk with parents about difficult things.

It can help to:
- Choose a time and place where you are both at ease and will have time to talk
- Be open and honest. Tell them you care about them and will always listen or talk when they want to
- Ask open-ended questions e.g. “Is there something troubling you?”

People sometimes say they are ‘depressed’ when they feel sad or low. But depression is more than short-term sadness or a passing phase. It can be a serious condition that needs professional diagnosis and treatment.

- Show that you’ve noticed how they seem to be feeling and that you care e.g. “I’m worried that you seem so upset at the moment”
- Listen to them. Young people sometimes want to talk without hearing advice. Save suggestions for another time and make neutral comments e.g. “I can see how that would upset you”
- Stay calm and in control. Be fair and consistent and think before you react
- Be prepared to admit that you don’t know everything
- Apologise if you get things wrong. This teaches valuable lessons e.g. being flexible, communicating well and taking responsibility for your words and actions.

GETTING HELP
Parents
It might be time to get help if:
- Talking with your child hasn’t helped and you are still worried
- Your child’s school, work, friendships or social activities are affected
- Your child’s low feelings persist.

Young people
Tell your child that everyone has problems that they can’t work out alone. Encourage them to talk with their doctor, school counsellor, or youth health service.

Let them choose whether they want to go with them or not. Don’t be upset about their choice. It may be easier for them to talk without you there.

If your child doesn’t want to talk about their feelings, says that nothing is wrong, or won’t talk with a professional, you may have to accept that it’s not the right time for them to get help. There’s only so much you can do. Be patient until they are ready.

DEPRESSION
Some young people who feel low for periods of time may be diagnosed with depression.
People sometimes say they are 'depressed' when they feel sad or low. But depression is more than short-term sadness or a passing phase. It can be a serious condition that needs professional diagnosis and treatment. It can affect the person’s thoughts, mood, behaviour and health. It leaves them feeling down for much of the time and makes it hard to cope from day to day.

Sometimes the causes of depression are clear, but sometimes they are not.

Depression can be caused by recent events, long-term stress or a mix of both. It is more likely:
- If someone else in the family has depression
- If someone has low self-esteem, is anxious or overly-sensitive.

There is a range of different treatments for depression varying from counselling and therapy to group and peer support or a combination of these. Antidepressant medication is not recommended for young teenagers. The right treatment will depend on the individual’s needs and situation. It is important to persist until the right support is found as often young people are particular about who they will talk to.

Let your child know you care about them and how they are feeling. Be ready to talk with them, or just listen.

Most people who are unhappy or diagnosed with depression do not hurt themselves (self-harm) or attempt suicide. But some young people do think about these and act on their thoughts.

SELF-HARM AND SUICIDE

Most people who are unhappy or diagnosed with depression do not hurt themselves (self-harm) or attempt suicide. But some young people do think about these and act on their thoughts.

Some young people self-harm by cutting their skin. This causes pain that helps the pain of their thoughts and feelings to go away for a while. If your child is doing this it’s important to let them know that you are worried about them. Seek professional help.

Some young people consider suicide. Usually they don’t want to die; they just want the pain of their feelings to stop.

Signs that a young person may be thinking about suicide include:
- Talk or threats of suicide
- Previous attempts
- Hints e.g. “I won’t be a problem for you much longer”
- Giving away their possessions or getting things in order.

All threats of suicide or self-harm should be taken seriously.

Seek professional help. Some contacts are provided on the following page. Give these contacts to your child too.

Some people think that talking about suicide may put the idea into a child’s head. But talking openly about suicide can help a young person to talk about their feelings and look for other ways to stop their pain. Talking also helps you to find out what your child is thinking.

If your child is thinking of suicide, help them work out how they will stay safe now, and in the weeks to come. Ask them what help they need from you.

All threats of suicide and self-harm should be taken seriously.

LOOKING AFTER YOURSELF

Parents can feel tired, angry or upset when their child is unhappy or depressed.
It is important to look after yourself so that you can help your child. Take time to relax and do things you enjoy. Try to exercise, eat well and get plenty of sleep. Talk with supportive family members and friends.

**WEBSITES**

*ReachOut.com*
Information and resources on topics including depression and mental health issues.
http://au.reachout.com

*Youthbeyondblue*
Information and resources for young people, parents and carers on depression, anxiety and other mental health issues.
Phone 1300 22 4636
www.youthbeyondblue.com

*headspace*
The National Youth Mental Health Foundation provides health advice, support and information to young people 12-25 years.
www.headspace.org.au

*Parenting SA*
PEG 71 ‘Young people, feelings and depression’

For other Parent Easy Guides e.g. ‘Living with teens’, ‘Young people and drugs’, ‘Young people and parties’, ‘Cybersafety’, ‘Abuse of parents’ and parent groups in your area.
www.parenting.sa.gov.au

---

**ONLINE TOOLS TO HELP YOUNG PEOPLE IMPROVE THEIR MENTAL HEALTH**

Psychologist and Young and Well CRC Director Dr Michael Carr-Gregg has explored apps and websites that can complement treatment.

**Why use technology with young people?**
Dr Michael Carr-Gregg said “Young people love technology. It’s low cost, which is important as young people tend to be price sensitive. Plus technology is a part of their world and what they are doing day to day. It’s the way it is and it’s how they communicate, and anyone working in adolescent health really needs to be thinking about working this way.”

*To find out more have a look at the interview with Dr Michael Carr-Gregg ‘Psychologist Interview: Dr Michael Carr-Gregg on Great Tools to Use with Young People’ at www.youngandwellcrc.org.au*

---

This information should not be used as an alternative to professional care. If you have a particular problem, see a doctor, or ring the Parent Helpline on 1300 364 100 (local call cost from anywhere in South Australia).

This topic may use ‘he’ and ‘she’ in turn – please change to suit your child’s sex.

---


---

This e-book is subject to the terms and conditions of a non-exclusive and non-transferable SITE LICENCE AGREEMENT between THE SPINNEY PRESS and: Trinity College, East Perth, library@trinity.wa.edu.au
DEPRESSION: Q&AS

THE QUESTIONS LISTED BELOW ARE THE MOST COMMON QUESTIONS THE BLACK DOG INSTITUTE GETS ASKED ABOUT DEPRESSION

1. What are the signs of depression?
2. How depressed should I be before I seek help?
3. What should I do if I’m feeling (or someone close to me is feeling) suicidal?
4. Am I always going to feel like this?
5. How long does depression last?
6. How is depression treated?
7. Where can I get help for depression?
8. How should I behave with someone who is depressed?

1. **What are the signs of depression?**

The following is a list of the features that may be experienced by someone with depression.

- Lowered self-esteem
- Change in sleep patterns
- Change in mood control
- Varying emotions throughout the day
- Change in appetite and weight
- Reduced ability to enjoy things
- Reduced ability to tolerate pain
- Reduced sex drive
- Suicidal thoughts
- Impaired concentration and memory
- Loss of motivation and drive
- Increase in fatigue
- Change in movement
- Being out of touch with reality.

Note that, having one or other of these features, by themselves, is unlikely to indicate that someone is clinically depressed. Also, having these features for only a short period (of less than two weeks) is unlikely to indicate clinical depression. It’s also important to know that many of the above features could be caused by or related to other things, such as a physical illness, the effects of medications, or stress. Help in coming to such decisions should be assisted by a proper assessment by a trained professional.

2. **How depressed should I be before I seek help?**

Everybody feels down or sad at times. But it’s important to be able to recognise when depression has become more than a temporary thing, and when to seek help.

As a general rule of thumb, if your feelings of depression persist for most of every day for two weeks or longer, and interfere with your ability to manage at home and at work or school, then a depression of such intensity and duration may require treatment, and should certainly benefit from assessment by a skilled professional.

3. **What should I do if I’m feeling (or someone close to me is feeling) suicidal?**

- See the list of emergency contact numbers at www.blackdoginstitute.org.au/public/gettinghelp/emergencyhelp.cfm (and add the numbers of your General Practitioner and your local Community Mental Health Service) and keep a copy handy.
somewhere. Don’t hesitate to call one of them if in need of help.

- Recognise that having suicidal thoughts is one of the features of depression, and seek help, either from your General Practitioner or another mental health professional such as a psychologist or a counsellor. Make sure you tell them you have been having suicidal thoughts.

- If you have already received treatment for depression, and you are having suicidal thoughts, contact the person who has been giving you the treatment, or a close friend who you trust, and tell them you are feeling suicidal.

- If someone close to you is suicidal or unsafe, talk to them about it and encourage them to seek help. Help the person to develop an action plan, involving him or her and trusted close friends or family members, to keep him or her safe in times of emergency.

- Take away risks, make sure you or the person who are concerned for is in a safe environment.

4. Am I always going to feel like this?

This is a common fear. It’s important to know that it will pass. Depression can be successfully treated and that you will feel better in time and with the right treatment.

5. How long does depression last?

Sometimes depression goes away of its own accord, but, depending on the nature and type of the depression, it may take many months and possibly considerable suffering and disruption if left untreated. Allow yourself to seek help in the same way you might if you had a physical illness.

6. How is depression treated?

There are a large number of different treatments for depression. At the Black Dog Institute we believe that different types of depression respond best to different treatments and it is therefore important that a thorough and thoughtful assessment be carried out before any treatment is prescribed.

If you have already received treatment for depression, and you are having suicidal thoughts, contact the person who has been giving you the treatment, or a close friend who you trust, and tell them you are feeling suicidal.

Treatments can fall into the following categories:

- Physical treatments, comprising:
  - Drug treatments, of which there are three main groups: antidepressants, tranquillisers, and mood stabilisers.
  - Electroconvulsive therapy – a physical therapy that may be relevant in a minority of cases of psychotic depression, severe melancholia or life-threatening mania.
- Transcranial magnetic stimulation – a treatment that is still under development, but which involves holding a coil near to a patient’s head and creating a magnetic field to stimulate relevant parts of the brain.

Psychological treatments, the most common ones being:

- Cognitive Behaviour Therapy – a form of therapy that aims to show people how their thinking affects their mood and to teach them to think in a less negative (and more ‘realistic’) way about life and themselves.
- Interpersonal Therapy – a therapy that aims to help people understand how social functioning (work, relationships and social roles) and personality operate in their lives to affect their mood.
- Psychotherapy – an extended treatment aimed at exploring aspects of the person’s past in great depth to identify links to the current depression.
- Counselling – a broad set of approaches and goals that provide problem solving and learning skills to cope with difficult life circumstances.

7. Where can I get help for depression?

A good first place to start in getting help is to visit your local General Practitioner. Let him or her know if you think you might have depression. Your General Practitioner will either conduct an assessment of you to find out whether you have depression, or refer you to someone else, such as a psychiatrist or a psychologist.

Depending on the nature of your depression, your General Practitioner may recommend some psychological intervention, such as cognitive behaviour therapy or interpersonal therapy, and might...
prescribe antidepressant medication to relieve some of the symptoms of depression.

Because depression is a common experience these days, many General Practitioners are used to dealing with depression and other mental health problems. Some General Practitioners take a special interest in mental health issues and undergo additional training in the area. If you don’t feel comfortable talking to your own doctor, find another one with whom you do feel comfortable. It is important that you feel comfortable talking about how you are feeling with your doctor so they have as much information to help you as possible.

If you are having trouble tracking down such a General Practitioner, you could telephone general practices in your area to find out whether any doctors in that practice have a particularly strong interest in mental health and, if so, whether they are taking on new patients. (Ask to speak to the practice manager.)

Psychologists, psychiatrists and counsellors are other professionals trained to provide help for depression and mood disorders. You will need a referral from your doctor to see a psychiatrist (and this will either eliminate or reduce costs).

Social workers, occupational therapists and registered nurses are also trained in mental health.

If someone close to you is suicidal or unsafe, talk to them about it and encourage them to seek help. Help the person to develop an action plan, involving him or her and trusted close friends or family members, to keep him or her safe in times of emergency.

8. How should I behave with someone who is depressed?

Someone with a depressive illness is like anyone with an illness – they require our care.

You can provide better care if you are able to:

- Understand something about the illness
- Understand what the treatment is, why it is being given, and how long the person is expected to take to recover.

An important part of caring is to help the treatment process:

- If medication is prescribed encourage the person to persist with treatment (especially when there are side-effects).
- Counselling or psychotherapy often results in the depressed person ‘thinking over’ their life and relationships. While this can be difficult for all concerned, you should not try and steer the person away from these issues.
- A resolving depression sometimes sees strong emotions released which may be hard on the carer. The first step in dealing with these fairly is to sort out which emotions really refer to the carer and which refer to other people or to the person themselves.
- Treatment has a positive time as well – when the person starts to re-engage with the good things in life and carers can have their needs met as well.

Don’t forget that as a carer you too are likely to be under stress. Depression and hopelessness have a way of affecting the people around them. Therapy can release difficult thoughts and emotions in carers too. So part of caring is to care for your own self – preventing physical run-down and dealing with the thoughts and emotions within yourself.

DEPRESSION DIAGNOSIS

THIS DEPRESSION INFORMATION IS COURTESY OF BLUEPAGES

If you are clinically depressed you would have at least two of the following symptoms for at least 2 weeks

• An unusually sad mood that does not go away
• Loss of enjoyment and interest in activities that used to be enjoyable
• Tiredness and lack of energy.

As well, people who are depressed often have other symptoms such as:

• Loss of confidence in themselves or poor self-esteem
• Feeling guilty when they are not at fault
• Wishing they were dead
• Difficulty concentrating or making decisions
• Moving more slowly or, sometimes becoming agitated and unable to settle
• Having sleeping difficulties or, sometimes, sleeping too much
• Loss of interest in food or, sometimes eating too much. Changes in eating habits may lead to either loss of weight or putting on weight.

Not every person who is depressed has all these symptoms. People who are more severely depressed will have more symptoms than those who are mildly depressed.

Here is a guide to severity of depression:

Mild depression: 4 of the 10 symptoms listed above over the past 2 weeks.
Moderate depression: 6 of the 10 symptoms of the past 2 weeks.
Severe depression: 8 of the 10 symptoms over the past 2 weeks.

Occasionally, depression is a sign of another illness or is caused by the side effects of medications. Your doctor will want to check out whether there are any other medical problems or pills that could be causing your depression.

If you think you might be depressed, you should seek help from your GP or other appropriate health professional.

References


DEPRESSION SELF-TEST

This self-test provided by the Black Dog Institute is a self-assessment tool for identifying possible symptoms of clinical depression. Please note that while great care is taken with the development of this self-assessment tool, it is not intended to be a substitute for professional clinical advice. While the results of the self-assessment tool may be of assistance, users should always seek the advice of a qualified health provider with any questions they have regarding their health.

SELF-TEST

Please consider the following questions and rate how true each one is in relation to how you have been feeling lately (i.e. in the last two to three days) compared to how you usually or normally feel.

RESULTS

Nine or more

If these feelings persist for more than two weeks there is a good chance that you are clinically depressed. It is worth you speaking to a GP to clarify this possibility.

Less than nine

Your results suggest you are unlikely to be clinically depressed. However, it might be helpful to see a GP as your symptoms might be linked to a physical cause.

Where to get more information

The self-test used in this fact sheet is the DMI-10 and the main reference is:


Less than nine

Your results suggest you are unlikely to be clinically depressed. However, it might be helpful to see a GP as your symptoms might be linked to a physical cause.

Where to get more information

The self-test used in this fact sheet is the DMI-10 and the main reference is:

Dealing with Depression Issues in Society | Volume 392

Tackling depression as early as possible may mean that you can address problems quickly and avoid symptoms becoming worse. There are various signs to watch out for. Knowing how to manage these signs and where to get support can help you cope with and recover from depression.

**Depression is common**

One in five women and one in eight men suffer from depression at some time in their life. Different types of depression exist, with symptoms ranging from relatively minor (but disabling) to very severe.

**Seek help for depression**

If you experience some or most of the symptoms of depression, seek advice from a doctor or counsellor. Don’t delay. Tackling depression early can help you address problems quickly and avoid symptoms becoming worse.

**Types of depression**

Different types of depression often have slightly different symptoms.

The main types of depression are:
- Major depressive disorder
- Bipolar disorder (which used to be called manic depression)
- Cyclothymic disorder
- Dysthymia
- Seasonal affective disorder (SAD).

**Treatment for depression**

Depression is often not recognised and can go on for months or even years if left untreated. Seek help early. The sooner a person gets treatment, the greater their chance of a faster recovery. A range of treatments, health professionals and services are available, and there are many things that people can do to help themselves.

Different types of depression require different treatment. Mild symptoms may be relieved with lifestyle changes (such as regular physical exercise) and self-help (for example, online e-therapies). For moderate to more severe depression, psychological or medical treatments are likely to be required, with a combination of treatments often being the most useful.

Treatment for depression should start with seeing your doctor. Book an extended consultation to give you time to discuss your symptoms and treatment options. Treatment might include medication, therapy or both.

Your doctor may refer you to a psychiatrist or psychologist. However, it can sometimes be difficult to get an appointment with a psychiatrist and you may need to wait some time before you can be seen. Whether this is okay for you will depend on the severity of your depression. If you feel that you need to see someone sooner, let your doctor know and work with them to find a solution.

Another option is your local community health centre. Your local council will have contact details. Most major hospitals also have a psychiatric department with staff available for assessments. If it is an emergency, call your local mental health crisis number for advice.

**Psychological treatments for depression**

Psychological treatments (talking therapies) help people change negative patterns of thinking and sort out relationship difficulties. They improve coping skills so people feel more able to deal with life’s stresses and conflicts, and help to prevent relapse once the person is well again.

These treatments include cognitive behaviour therapy, interpersonal therapy and family therapy. You can also access a psychologist through Medicare. This requires that your doctor writes a mental health plan – ask them for more details.

**Antidepressant medications**

Antidepressants are often prescribed alongside psychological treatments when a person experiences a moderate to severe episode of depression.

Antidepressants take at least two weeks before they start to help, and it may also take some time for your doctor to find the most suitable medication and dosage. It is important to persist with your medication, even if it doesn’t seem to be making a difference at first. Stopping medication should only be done gradually, on a doctor’s recommendation and under supervision.

Like with any other medication, some people will experience some side effects. Discuss any side effects of the medication or issues with your doctor or therapist. Remember, everyone is different and many people need to try a number of medications and treatment approaches before they find one that suits them. Don’t give up – keep talking to your doctor about finding medication that works for you.

**Depression – coping and recovering**

Medical help is very important, but there are also things you can do every day to help your recovery.
Enjoying activities

When you are depressed, you might not enjoy activities that you once loved. You might also think you won’t enjoy something but, when you do it, you actually enjoy it more than you expected.

If you don’t try activities, you reduce the number of things that may help you cope with your depression.

To increase the amount of activities you enjoy, you can:
- List activities you used to enjoy – include as many as possible.
- Plan one of these activities each day.
- Increase the amount of time available for activities you enjoy.
- After an activity, think about or write down what you enjoyed about it.
- Talk to others about activities they like.

If you keep going, it will help you get better. You will enjoy activities more as you recover.

Sleeping patterns and depression

Changes in sleeping patterns are common in people experiencing depression.

Not sleeping enough or sleeping too much can make you feel worse, but you can help by:
- Getting up at the same time every morning, regardless of how tired you feel.
- Avoiding sleeping during the day or taking a nap before bedtime.
- Drinking no more than four cups of tea or coffee a day, and don’t have either after 4 pm.
- Getting out of bed and going to another room if you are awake at night. Try to relax – for example, by reading, drinking warm milk, listening to music or doing relaxation exercises.
- Doing regular exercise earlier in the day.

Negative thoughts and depression

Worrying or thinking negatively is common in people with depression. This affects your ability to focus on getting better and makes you more vulnerable to unhealthy emotions.

Tips to help you control worry and reduce negative thinking include:
- Write down what you are worried about. Go through each concern and examine all the possible positive and negative outcomes.
- Think about how realistic your negative thoughts are. Explore alternative thoughts and explanations.
- Avoid talking about negative thoughts and feelings. Try to find realistic thoughts, which will at least balance your negative ones.
- Keep busy and focused on tasks.
- Think about your skills, talents and achievements. Look at the good things around you. Remember happy times.
- Write down your thoughts.

Identify negative ones and try to correct them.
- Avoid making major decisions about your life at this time.

Dealing with irritability, agitation and fatigue

People with depression often experience irritability, agitation and fatigue. These feelings can become worse because of changes in sleeping patterns and lifestyle.

Help yourself to deal with this by:
- Telling your friends, family and colleagues what you are going through and that you may appear to be irritable.
- When you are agitated or irritable, stopping and thinking about what is causing you to feel this way and how you can calm down.
- Practising regular relaxation to reduce the effects of irritating or frustrating situations.
- Talking to people who are...
supportive.
• Being as active as possible, despite fatigue. Schedule activities each day, such as exercise, meeting people, going on outings or even doing household chores.

Treatments for seasonal affective disorder (SAD)
Treatments for SAD might include phototherapy (controlled use of artificial light that mimics the sunlight spectrum), medications or psychotherapy.

Be guided by your doctor, but SAD can be helped if you:
• Increase your exposure to sunlight every day.
• Bring sunshine into your home – install skylights, keep the curtains open.
• Get regular outdoor exercise.
• Look after yourself – have good sleeping habits and eat a healthy diet.
• Avoid cigarettes, drugs and excessive alcohol.
• Holiday in a warmer, sunnier climate during winter.

Where to get help
• Your doctor
• Your local community health centre
• Beyondblue support service

Tel. 1300 22 4636
• Lifeline Tel. 13 11 14
• Kids Helpline Tel. 1800 55 1800
• SuicideLine Tel. 1300 651 251
• SANE Mental Health Information Line Tel. 1800 18 7263, Monday to Friday, 9am to 5pm
• Australian Psychological Society – Find a psychologist service Tel. 1800 333 497
• AREFEMI (Association of Relatives and Friends of the Emotionally and Mentally Ill) Tel. (03) 9810 9300.

Things to remember
• If you feel depressed, see your doctor for an assessment.
• Don’t delay. Tackle depression early to address problems quickly and avoid symptoms becoming worse.
• Depression can be mistaken for a physical illness, such as fatigue.
• Antidepressants can help most depressed people, but they must be accompanied by psychological therapy and education.
• Take the time to find the treatment that’s right for you.
• Medications may take up to six weeks to be effective, so be patient.
• Medical help is very important, but there are also things you can do every day to help your recovery.

This fact sheet was produced in consultation with and approved by, beyondblue.

Copyright © 1999/2014 State of Victoria. Reproduced from the Better Health Channel (www.betterhealth.vic.gov.au) at no cost with permission of the Victorian Minister for Health. The information published here was accurate at the time of publication and is not intended to take the place of medical advice. Unauthorised reproduction and other uses comprised in the copyright are prohibited without permission.

TREATMENT FOR DEPRESSION

DEPRESSED BUT CONVINCED NOTHING WILL HELP? THIS INFORMATION FROM BLUEPAGES EXPLORES A RANGE OF TREATMENT OPTIONS

DEPRESSION CAN BE TREATED

The National Institute for Mental Health Research has reviewed the scientific evidence for a range of conventional and alternative and self-help ‘treatments’ for depression. Some treatments are effective, some are promising but require more study, and others are not supported by scientific evidence.

• Check out our rating system
• Find out how to work out how good particular evidence is
• Find out what works for depression (and what doesn’t).

OUR RATING SYSTEM

How useful are treatments?

😊😊😊 These treatments are very useful. They are strongly supported as effective by scientific evidence.

😊😊 These treatments are useful. They are supported by scientific evidence as effective, but the evidence is not as strong.

😊 These treatments are promising and may be useful. They have some evidence to support them, but more evidence is needed to be sure they work.

😀 On the available evidence, these treatments do not seem to be effective.

❓ These treatments have not been properly researched. It is not possible to say whether they are useful or not.

SCIENTIFIC EVIDENCE

Like clothes and cars, scientific evidence varies in quality. When you read a claim that a treatment works it is a good idea to try to work out how good the evidence really is.

Randomised controlled trials (RCTs): the best evidence

The randomised controlled trial is the Rolls Royce of scientific evidence. In an RCT, the people who volunteer to test out the treatment are randomly placed either in a treatment group (e.g. given antidepressants) or a no treatment group (e.g. given a sugar pill). A systematic review is a special unbiased method of identifying all relevant trials of a treatment and combining the results. The best possible evidence comes from a systematic review of all RCTs of a treatment.

Controlled trial, not randomised: the next best evidence

Sometimes scientists use controlled trials where volunteers are not randomly placed in groups. Suppose we give all the patients from a depression clinic in Melbourne a secret depression buster formula. At the same time we give all the patients from a depression clinic in Sydney sugar pills.

We find that the Melbourne patients recover more quickly than the Sydney patients. We might conclude that the depression buster formula works. We could well be right. However, we can’t be sure. The difference between the two groups might reflect a difference in the clinics, a difference in the type of people who attend the clinics, or something different about the two cities. The non-randomised controlled trial is good evidence but not as good as the RCT.

Before and after group study

Another type of evidence involves measuring health before and after treatment. If there is an improvement, we might conclude that a treatment works. The problem with this type of study is that we can’t be sure that an improvement is due to the treatment. The volunteers might have improved anyway. This type of study is not as good as a study with a control group.

Little or no evidence

Sometimes people claim that a treatment works on the basis of their personal or professional experience. For example, Mary Downtheroad tells her friends that pulling her ears three times each morning has changed her life. Now life is wonderful and she no longer becomes depressed. Mary believes that ear pulling has helped...
her but she cannot provide any scientific evidence to support her belief. Maybe trials in the future will prove her correct and perhaps they won’t. This anecdotal information is the Roller Skates of scientific evidence – you can’t tell if and when you will crash.

**What else is important?**

*Studies should involve enough people that we can be confident of the findings*

The larger a study, the more likely we are to find an effect of treatment if it exists.

**The best studies are ‘blind’**

A blind study means that the people involved in the study do not know who is receiving the treatment and who is not. (In a single blind study, the patients do not know if they have been given the active treatment or the placebo. In a double blind study, neither the volunteers nor the people treating or assessing them know who is receiving the actual treatment). The advantage of a blind study is that the volunteers and researchers cannot consciously or unconsciously bias the results of the study.

**Findings should be tested for statistical significance**

Sometimes differences occur by chance. There are special statistical methods for deciding if a difference between two groups (e.g. one that receives a treatment and one that doesn’t) is real. All good studies should report whether a finding is statistically significant.

**Findings should be meaningful**

Sometimes a treatment can produce a real (statistical) effect but the effect is not very large. All other things being equal, a treatment that makes a large difference is better than a treatment that makes a small difference.

**WHAT WORKS FOR DEPRESSION (AND WHAT DOESN’T)**

Some people prefer medical treatments, some prefer psychological therapy and others are most interested in alternative treatments and lifestyle changes.

Select the treatment that interests you and find out if it is likely to help.

**Medical treatments**

- Dehydroepiandrosterone (DHEA)
- Antidepressants
- Electroconvulsive therapy
- Oestrogen
- Transcranial magnetic stimulation
- Tranquilisers

**Psychological treatments**

- Bibliotherapy
- Cognitive behaviour therapy
- Hypnotherapy
- Interpersonal psychotherapy

**Lifestyle and alternative treatments**

- Exercise
- Fish oils (see Omega-3)
- Ginkgo biloba
- Ginseng
- Glutamine
- Homeopathy
- Inositol
- Lemon balm
- Light therapy
- Massage therapy
- Meditation
- Multivitamins
- Music
- Natural progesterone
- Negative air ionisation
- Omega-3
- Painkillers
- Pets and animal-assisted therapy
- Phenylalanine
- Pleasant activities
- Relaxation therapy
- Saffron
- SAMe
- Selenium
- St John’s wort
- Sugar avoidance
- Tai Chi and Qigong
- Tryptophan
- Tyrosine
- Vervain
- Vitamins B6, B9 (Folate), B12
- Vitamin D
- Yoga

Go to the BluePages website for hyperlinks containing helpful information on each of the rated treatment options listed above.

---

This e-book is subject to the terms and conditions of a non-exclusive and non-transferable SITE LICENCE AGREEMENT between THE SPINNEY PRESS and; Trinity College, East Perth, library@trinity.wa.edu.au
What are antidepressants?

Antidepressants are medicines that treat depression and its symptoms.

There are several different types of antidepressants, including:

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and noradrenaline reuptake inhibitors (SNRIs)
- Tricyclic antidepressants (TCAs)
- Monoamine oxidase inhibitors (MAOIs)
- Reversible inhibitors of monoamine oxidase (RIMAs)
- Noradrenaline-serotonin specific antidepressants (NASSAs), and
- Noradrenaline reuptake inhibitors.

Antidepressant medicines are not stimulants or ‘uppers’, they do not change your personality and they are not addictive. They reduce the symptoms of depression by correcting chemical imbalances in the brain. Each class, or type, of antidepressant works on brain chemistry in a different way.

When antidepressants are used properly, they can be extremely effective in treating depression and helping depressed people feel like themselves again.

Antidepressant medicines are also used in the treatment of anxiety disorders and bulimia nervosa, and sometimes in the treatment of chronic pain.

Do antidepressants work?

Antidepressants are usually used to treat moderate to severe depression. Doctors estimate that 50 to 70 per cent of people who have major depression are helped by initial antidepressant medication.

Talk to your doctor if you have been experiencing a recent loss of pleasure in your usual activities, or have other symptoms of depression such as:

- Restless sleep

When antidepressants are used properly, they can be extremely effective in treating depression and helping depressed people feel like themselves again.

- Waking very early in the morning
- Loss of appetite, or
- Feelings of hopelessness or guilt.

Are antidepressants suitable for me?

If your doctor believes antidepressants will be likely to help you, he or she will assess your symptoms based on a number of factors, some of which are:

- How severe your depression is
- Your past medical history
- Your current medical problems and medicines being taken
- Whether any antidepressant medicines have worked for you in the past, and
- The side effects you might be likely to experience.

It is very important that you follow your doctor’s instructions so that you have the best chance of a full recovery. He or she might tell you that you need to take antidepressants for what appears to be a long time – usually at least 6 to 12 months. You should follow this advice, and do not stop taking the medicine as soon as you begin to feel better. Your symptoms may return if you stop the medicine before your doctor recommends.

What if I don’t want to take antidepressants?

Depression is a serious illness, and without appropriate treatment it can have a serious impact on your health. In severe cases depression can be life-threatening.
TYPES OF ANTIDEPRESSANTS

There are several classes of antidepressant medications available in Australia. They all have side-effects depending on which medication is taken, including nausea, headaches, anxiety, sweating, dizziness, agitation, weight gain, dry mouth and sexual difficulties. Some side-effects are short-lived, however people experiencing any of these symptoms should inform their doctor for advice on ways of minimising the symptoms.

Selective serotonin reuptake inhibitors
- SSRIs available in Australia include: citalopram (Cipramil); escitalopram (Lexapro); fluoxetine (Prozac); fluvoxamine (Luvox); paroxetine (Aropax); and sertraline (Zoloft).
- Most commonly prescribed antidepressants in Australia
- Often doctors’ first choice for most types of depression
- Generally well-tolerated by most users
- Generally non-sedating.

Serotonin and noradrenaline reuptake inhibitors
- Three SNRIs are available in Australia: venlafaxine (brand name Efexor-XR), duloxetine (Cymbalta) and desvenlafaxine (Pristiq).
- Fewer side effects compared to older antidepressant classes
- Often prescribed for severe depression
- Safer if a person overdoses.

Reversible inhibitors of monoamine oxidase
- RIMAs include moclobemide.
- Fewer side-effects
- Non-sedating
- May be less effective in treating more severe forms of depression
- Helpful with problems relating to anxiety or sleeping.

Tricyclic antidepressants
- TCAs include imipramine (e.g. Tofranil, Tolerade); nortriptyline (e.g. Allegron); amitriptyline (e.g. Endep); dothiepin (e.g. Dothep); clomipramine (e.g. Anafranil); trimipramine (e.g. Surmontil); and doxepin (e.g. Sinequan).
- Effective, but have more harmful side-effects than the newer classes of drugs (i.e. SSRIs)
- Some evidence TCAs are most effective for people with severe depression compared with those with mild to moderate depression
- More likely to cause low blood pressure, which should be monitored by a doctor.

Noradrenaline-serotonin specific antidepressants
- NASSAs include mirtazapine.
- Relatively new antidepressant medications
- Helpful with problems relating to anxiety or sleeping
- Low sexual side effects, however may cause weight gain.

Noradrenaline reuptake inhibitors
- NARIs include reboxetine.
- Acts selectively on the brain chemical, noradrenalin
- Less likely to cause sleepiness or drowsiness than some other medicines
- More likely to make it difficult for people to sleep; and more likely to cause these side-effects after initial doses – increased sweating, sexual difficulties, difficulty urinating, increased heart rate.

Monoamine oxidase inhibitors
- MAOIs used in Australia are: phenelzine (brand name Nardil) and tranylcypromine (brand name Parnate).
- Prescribed only under exceptional circumstances as they require a special diet and have adverse effects.

Sources:
myDr www.mydr.com.au
dNet http://depressionet.org.au
beyondblue www.beyondblue.org.au
Doctors often prescribe psychological treatment in conjunction with antidepressants for the treatment of depression. For people with mild or moderate depression, psychological treatment alone may be appropriate. Your doctor will discuss with you the most appropriate treatment for you based on your symptoms and past history.

**How soon will I feel better?**

It will probably be one to two weeks after starting the medicine before you begin to feel better, so do not be discouraged if things do not improve straight away. It may take 6 weeks or longer for you to feel the full benefit of antidepressant treatment. Also, some of your symptoms might get better sooner than others – if you have sleeplessness, for example, this might go away before your mood improves.

If you think your antidepressant medicine is not working for you, see your doctor. It’s important that you don’t just stop taking your antidepressants, because stopping abruptly can make you feel agitated and unwell. Antidepressants generally need to be stopped slowly by gradually reducing the dose.

If the first antidepressant you are prescribed doesn’t work for you, your doctor may recommend you try a different type. To avoid interactions between the different antidepressants, you may have to wait a couple of days to 2 weeks before starting your new antidepressant, depending on the medicines used. Some people may need to try several different medicines before they find the one that works for them.

**REFERENCES**

Antidepressant prescribing has been increasing in most developed countries since the late 1980s and early 1990s. It’s important to consider whether the increase in prescribing is justified at both a national public health and individual clinical level. An article from The Conversation by Professor Philip Mitchell

The British Medical Journal (BMJ) has just published two opposing views on the vexed question of whether antidepressants are being over-prescribed. The issues raised by debate are by no means unique to the United Kingdom; increasing rates of antidepressant prescribing are apparent in most developed countries, including Australia.

The BMJ discussion was precipitated by recent UK prescribing data, which reported a 9.6% increase in antidepressant prescriptions in 2011 – the largest increase in prescriptions of all medication classes for that year.

Arguing that the figures indicated over-prescribing, general practitioner Des Spence writes, “I think that we use antidepressants too easily, for too long, and that they are effective for few people (if at all).”

In the opposing camp, professor of psychiatry Ian Reid contends, “Given recent demonstrations that depression is still under-recognised and under-treated, the claim that antidepressants are over-prescribed needs careful consideration.”

SITUATION IN AUSTRALIA

A recent report on prescribing patterns of antidepressants and other psychotropic medications (drugs for mental illnesses) has aroused similar controversy in the local media. The study’s authors reported a 58.2% increase in the dispensing of psychotropic drugs over the period from 2000 to 2011, including a 95.3% increase in antidepressants.

Echoing the argument that antidepressants are being over-prescribed, the authors raised concern about “... the dramatic increase in antidepressant prescriptions despite questions about the efficacy of these drugs in mild to moderate depression.”

These recent UK and Australian data are not surprising; they are consistent with the major increase in antidepressant prescribing that’s been occurring in most developed countries since the introduction of the SSRI (selective serotonin reuptake inhibitor) antidepressants in the late 1980s and early 1990s.

AN INTERNATIONAL TREND

In 2000, my colleagues and I wrote one of the first major reports of this global trend. We found an approximately threefold increase in antidepressant prescribing in Australia from 1990 to 1998. The increase reflected what was occurring in most major Western countries and coincided with the widespread introduction of SSRI antidepressants such as Prozac, Zoloft, Aropax and Cipramil during that period.

In a another paper, we examined a longer timeframe (1975 to 2002) finding a 1.1% annual increase in antidepressant prescribing from 1975 to 1990, an acceleration to 29% in 1995, then a slowing down to 6.6% in 2002.

There’s no doubt there’s a continuing increase in the use of antidepressants in developed countries such as Australia and the UK, in the range of between 6% and 9% annually. The critical question, though, is whether
this substantial increase in prescribing is justified at both a national public health and the individual clinical level.

**BENEFIT OR HARM?**

In Australia, we are able to look at the question of benefit or harm by examining national epidemiological and suicide data.

In terms of adequacy of depression treatment, a 2007 national survey found that 6.2% of individuals had experienced a mood disorder (mainly depression) over the prior 12 months, but over half (51.2%) did not access any services for mental health problems in that time. This indicates a substantial unmet treatment need for depression, rather than over-treatment.

While it’s not possible to identify rates of antidepressant prescribing, as such, from the survey, the rate of use for psychological services was 23.2% for those with a mood disorder. This is a substantial increase from the 11.8% in an analogous 1997 survey, suggesting that doctors were readily utilising psychological services via Commonwealth-funded schemes such as Better Access.

Overall, these data do not indicate that there’s over-prescribing of antidepressants in Australia.

**ANTIDEPRESSANTS AND SUICIDE**

A second potential measure of the value or otherwise of this increase in antidepressant use is its impact on suicide rates.

We examined this question in 2003, and found there was a significant correlation between changes in antidepressant prescribing rates from 1991 to 2000 and the rates of suicide. We also found that people in age and gender groups with increased rates of prescribing demonstrating lower suicide rates.

This same finding has also been reported in the United States and Scandinavia, indicating that greater rates of effective treatment for depression in a population have a significant impact on suicide.

We interpreted our findings broadly – that effective treatment of depression, whether by medication or psychological treatment can lead to a measurable benefit (here a fall in suicide rates), even at a whole population level.

**ISSUES AROUND EFFECTIVENESS**

Another issue raised in the BMJ debate is the current state of knowledge about the effectiveness of antidepressants for those with mild depression – the most common form in the community. Unfortunately, current evidence is inconsistent and dependent on the methodology used by researchers.

A highly publicised 2008 meta-analysis of published and unpublished antidepressant trials found that only those with severe levels of depression benefited more from antidepressants than a placebo.

But a recent report examining longitudinal data from individual patients in a series of large antidepressant trials found no relationship between likelihood of benefit from antidepressants and the initial severity of depression. In other words, patients benefited at similar rates independently of how severely depressed they were.

These inconsistent findings indicate the jury is still out on whether those with mild depression benefit from antidepressants.

**WHAT TO MAKE OF IT ALL?**

So, where does this leave us in determining whether current rates of antidepressant prescribing are excessive? While rates of prescribing are undoubtedly increasing, data from national surveys suggest continuing high rates of untreated depression as well as increased use of psychological services. And, as discussed above, findings from a number of developed countries, including Australia, indicate the public health benefit of reduced suicide rates.

Still, we must remain vigilant in monitoring such prescribing and avoid mindless use of antidepressants, particularly for milder levels of depression where psychological treatments are probably more appropriate.

If you think you may be experiencing depression or another mental health problem, please contact your general practitioner or in Australia, contact Lifeline 13 11 14 for support, beyondblue 1300 22 4636 or SANE Australia for information.

Philip Mitchell is Scientia Professor and Head of the School of Psychiatry at UNSW Australia.

---

Psychological interventions for depression

In this article the Australian Institute of Professional Counsellors summarises the top psychological interventions for dealing with depression.

Treatments (or interventions) for depression fall into one of three categories, and often several are recommended to be taken up at once. These main groupings are: medical interventions; psychological interventions and; lifestyle interventions.

Beyondblue, the Australian organisation set up to tackle depression in Australia, has an excellent resource, A guide to what works for depression (Jorm et al, 2009), which outlines the various interventions and rates them according to how effective they are.

Each type of intervention is rated as ‘thumbs down’ (let’s say, zero, or ‘don’t use’), ‘one thumb up’ (equivalent to a score of one, in cases where there are at least two good studies showing that the treatment works), ‘two thumbs up’ (given where there are a number of studies showing that the treatment works, but the evidence is not as strong as for the best treatments), or, for the best interventions, ‘three thumbs up’ (a score of three, given when many studies confirm that the treatment works).

In this article we summarise the top several interventions within the psychological interventions category (those receiving ‘two thumbs up’ or more).

Further reference: This article is based on beyondblue’s guide’s general framework for reporting on the various interventions (Jorm et al, 2009).

Cognitive behavioural therapy (CBT)

What is it? A person undergoing CBT works with a counsellor or other therapist to identify limiting or unhelpful patterns of thinking and behaviour which are making them depressed, or keeping them from getting better once they become depressed. Over the course of treatment (varying between four and 24 sessions), a client identifies the negative patterns and replaces them with thoughts (‘cognitions’) and behaviours which are more positive, realistic, and helpful.

This way of improving mood and coping skills can be conducted in one-on-one therapy or in group sessions. It works by helping the person make changes in the thinking and behaviour – such as self-focused, self-critical thinking and low-energy or avoidant behaviour – which is linked with the depression. Clients begin thinking in a more life-enhancing way, and resuming activities which they may have enjoyed before, or which give them a sense of achievement.

How effective is it? CBT has shown to be effective in reducing the effects of depression for most if not all client groups, including children, adolescents, adults, and older people. Its effectiveness has been shown in more high-quality studies than any other psychological intervention for depression. Some studies show that it is even better when combined with an antidepressant, but it works quite well on its own. It is also good as a tool for preventing relapse after recovery.

What are the risks? There are no known risks.

Advice in a line: CBT is one of the most effective treatments available for depression.

Interpersonal psychotherapy (IPT)

What is it? Proponents of IPT believe that interpersonal problems are a major cause of depression, and that by focusing on problems in personal relationships and building skills to deal with the problems, clients can come to feel better. Many of the other psychological therapies have the client’s mind as a focus (his or her thoughts and feelings). IPT, conversely, is focused on what is going on between the client and others in the client’s personal relationships.

The treatments vary, but often are conducted over four to 24 weekly sessions. By focusing together on the client’s specific interpersonal problems, client and therapist can identify the patterns in the client’s relationships with others which make the person more vulnerable to depression. Examples of problems could be grief or resentment over lost relationships, client role conflicts or the need to give up some roles and take on new ones, or angst at being over-controlled by others. As clients gain skills in dealing with different interpersonal situations, their mood improves.

How effective is it? Numerous well-designed studies have found IPT to be effective with many groups, including adults, older people, women with post-partum depression, people with HIV infections, and adolescents (this last group has been particularly well studied).

What are the risks? There are no known risks.

Advice in a line: IPT is effective in the treatment of depression.
**Behaviour therapy**

**What is it?** Also called behavioural activation, behaviour therapy is part of CBT (above), but only attempts to change people’s behaviour, not their thoughts or attitudes. It aims to increase the level of activity and pleasure people are experiencing in their life. Carried out with individuals or groups, behaviour therapy generally lasts between 8 and 16 weeks.

People learn to become more active, and the therapy work often involves doing activities that are rewarding, either because they are enjoyable or because they engender a sense of achievement or satisfaction. By engaging life activities, clients learn to replace patterns of avoidance, inactivity, and withdrawal, which make depression worse, with rewarding experiences that reduce depression.

**How effective is it?** Many studies have shown CBT, which behaviour therapy is part of, to be effective; far fewer have looked at behaviour therapy alone. Those studies (often well-designed) which have investigated the effects of behaviour therapy have found it to work as well as CBT, and some have even suggested that it may be better than CBT for severe depression.

**What are the risks?** There are no known risks.

**Advice in a line:** Behaviour therapy is an effective intervention for depression, and might be especially good for severe depression.

**Marital therapy**

**What is it?** A depressed person who is also having problems with their long-term relational partner or spouse may be prescribed marital therapy, in which both the depressed person and the partner attend counselling sessions over a period of eight to 24 weeks. A two-pronged approach, marital therapy aims both to reduce the number of unhelpful interactions – such as those involving criticisms, abuse, or arguments – and increase the helpful interactions, such as forgiveness, praise, compassion, and mutual problem-solving.

The focus in marital therapy is on changing behaviour, with the idea that, as the couple’s behaviour in the relationship improves, so too does their satisfaction with the relationship, along with the depressed partner’s mood.

**How effective is it?** Marital therapy has been shown by research to be far better than no treatment, and roughly as effective as well-established treatments. Obviously, it is most effective when the depressed person is having relational problems; many, but not all, clients are in this situation.

**What are the risks?** There are no known risks.

**Advice in a line:** Use marital therapy when there are primary relational problems going on for a depressed person.

**Problem-solving therapy**

**What is it?** In problem-solving therapy, a client learns from a therapist to go through the whole problem-solving cycle, including: identifying problems, generating solutions, choosing the best solutions, developing and carrying out a plan, and then evaluating to see if the plan worked. It is an effective counter to the depressed person’s perception that problems are too large, difficult, or all-encompassing to solve.

By using standard problem-solving techniques, the person learns to not avoid problems or to attempt to solve them through unhelpful means. Depression lifts as the person discovers new effective ways of dealing with their problems.

**How effective is it?** The pooled results of numerous well-designed studies show that problem-solving therapy does seem to work, but research is needed to understand the differences in results.

**What are the risks?** There are no known risks.

**Advice in a line:** Problem-solving therapy seems to be effective for depression, partly because it includes some aspects of CBT, a well-established treatment.

**Psychodynamic psychotherapy**

**What is it?** By focusing on the unconscious patterns of thoughts and feelings in clients’ minds, plus the unconscious patterns in their relationships, the psychodynamic psychotherapies (such as Freudian, Psychoanalysis, Object Relations, and Psychosynthesis) delve into issues that may be creating depression.

Often these originate in clients’ early childhood years. In these psychotherapies, the therapist uses the thoughts, images, and feelings that pass through the client’s mind, as well as the client’s relationship with the therapist, to uncover the patterns that give cues to internal conflicts in the client: conflicts often occurring out-of-awareness.

By becoming aware of them, clients can resolve the issues and lift the depression. Short-term psychotherapy may take between 20 and 30 weeks. Longer-term psychodynamic psychotherapy can take more than a year, sometimes many years.

**How effective is it?** There are not many studies looking at psychodynamic psychotherapy specifically for depression, but recent studies pooling the results of studies looking at the effectiveness of these methods for a range of mental health problems have found them to be better than no treatment, and just as effective as standard treatments (such as CBT) for mental health problems in general, including depression.

**What are the risks?** None to the clients, but the long term of treatment can be time-consuming, and thus damaging to their wallets.

**Advice in a line:** Both short-term and longer-term psychodynamic psychotherapy appear to work for depression. More large studies are needed to confirm what has already been shown.

* This article is an extract of the Mental Health Social Support Specialty
  * Supporting Those with Depression or Anxiety. For more information on MHSS, visit [www.mhss.net.au](http://www.mhss.net.au)

**REFERENCES**


People seeking therapy should always talk to a practitioner who provides good quality treatment that’s appropriate to their needs. Because research shows that even the innocuous-sounding ‘talking therapies’ (essentially counselling and psychotherapy) can be harmful for some when they’re unsuitable.

Reflecting my day job, I’m going to focus here on mood disorders. Some of these (melancholic depression, for instance, and bipolar disorder) are essentially ‘diseases’ because their causes are largely genetic, and reflect primary biological brain changes.

The wrong model

People with these mood disorders tend to respond to medication but not usually to talking therapies. Therapists with a narrow treatment approach will generally fail to be of any assistance to people who suffer from such conditions.

But sadly, as per the aphorism “if all you have is a hammer, then everything looks like a nail”, some therapists reject any possibility they might be providing totally inappropriate treatment.

I cringe when recipients of such treatment – many substantially impaired for years – tell me their practitioner has reassured them that their continuing depression (which might have responded within weeks to an antidepressant drug) needs to be “experienced before it can be worked through,” or some other defensive pseudo-profound explanation.

In such cases, talking therapies are indirectly harmful by being inappropriate and ineffective.

Conversely, there are many depressive disorders that lack primary biological changes. But, despite the most appropriate treatment here being a talking therapy, the individual receives a procession of inappropriate and ineffective antidepressant drugs that may also have distressing side effects.

Here again, harm – and a lack of therapeutic response – may arise from the wrong therapeutic model. But harm may also accrue from the ingredients of therapy and how they’re applied by individual therapists.

Cognitive behaviour therapy challenges faulty thinking patterns that cause people to view themselves, their future, and the world negatively.

Components and risks

Psychotherapies, such as cognitive behaviour therapy or dynamic psychotherapy, are all developed with an underlying logic and possess powerful specific ingredients.

Cognitive behaviour therapy, for instance, challenges faulty thinking patterns that cause people to view themselves, their future, and the world negatively. While dynamic psychotherapy, which is derived from psychoanalysis, is designed to identify the early formative events that led the individual to develop psychological problems.

But all psychotherapies also contain non-specific therapeutic ingredients that may – when present in some circumstances, or absent in others – benefit or harm the patient. These include the therapist being empathic, and providing a clear therapeutic rationale in a healing and restorative setting.

An analysis of several studies shows only 8% of patient improvement during psychotherapy is due to any specific therapy component.

Other research puts the figure at an estimated 15%, with the remainder emerging from non-specific components – a third from the therapeutic relationship, and some from patients ‘expecting’ to improve, but most improvement from patient and extra-therapy factors such as the therapist being empathic, offering a logical model, hope and expectancy of improvement.
But just as the ideal therapist can contribute significantly to improvement, if he or she lacks such ingredients – or is actively ‘toxic’ – then harm occurs.

Psychotherapists argue that because their work is “only talking ... no possible harm could ensue”. But all effective medication is accompanied by risk and the same holds for talking therapies.

The harm of talking therapies

In 2009, a colleague and I published an overview of reported harmful effects from talking therapies, examining scenarios such as the insensitive, critical, voyeuristic or sexually exploitative therapist, and their prevalence.

In a subsequent research report, we developed a measure of adverse therapeutic styles experienced by people who had received a psychological therapy and left or (perhaps more concerning), remained in therapy and had their condition worsen.

The most common ‘negative therapist’ style identified was a lack of empathy or respect, and not having the patient’s interests at heart. Next, was the ‘preoccupied therapist’ who made the patient feel alienated and powerless; the controlling therapist who encouraged dependency; and, finally, the passive therapist who was inactive, inexperienced or lacked credibility.

While side-effects from medicines are generally physical, the adverse effects of psychotherapy and counselling naturally tilt to the psychological. Unfortunately, there are no formal processes in place for evaluating professional psychotherapists and counsellors. While a therapist would not (and could not) allow an independent observer to judge the therapy on a session by session basis, there’s no reason why a patient cannot seek a second opinion from another therapist to determine if the therapy being received is cogent and provided at a professionally logical level.

Better ways

To avoid this, all health practitioners should be evaluated by their clients in terms of both style and substance. Most patients seek practitioners who meets both requirements; who are perceived as caring and technically proficient.

Informal ratings provided on platforms, such as websites, should not necessarily be trusted because ratings may be weighted to the aggrieved (satisfied customers are less likely to rate), and professional rivals may ‘load’ negative reports.

If someone is exploited or abused by a therapist, they should make a report to the appropriate professional disciplinary board. If the therapist is less overtly concerning (whether simply passive, on the wrong wavelength or causing you to feel troubled or even worse), best to cut and run.

You may have psychological problems but rely on your instincts; therapy that matches your needs is an incomparable balm and will advance your recovery. Therapy that fails this is not worth your while.

Gordon Parker is Scientia Professor at UNSW Australia.

There are a wide range of self-help measures and alternate therapies which can be useful for some types of depression, either alone or in conjunction with physical treatments (such as antidepressants) or psychological treatments, advises the Black Dog Institute.

However, the more biological types of depression (melancholic and psychotic depression) are very unlikely to respond to self-help and alternative therapies alone, although these can be valuable adjuncts to physical treatments.

What follows is not intended to be an exhaustive list, but includes those which are more commonly found helpful.

**BIBLIOTherapy**

Bibliotherapy involves, essentially, reading books or other materials (such as those available via the internet) on how to overcome depression and apply the practices oneself. The person works independently (or with some supervision) through the material, applying the techniques outlined in it. Bibliotherapy usually uses a cognitive behaviour therapy approach.

**Omega-3**

There is some evidence that Omega-3 oils, commonly found in fish such as salmon, tuna, mackerel and swordfish, play a role in mental wellbeing, particularly in cases of bipolar disorder, but some studies also demonstrate antidepressant properties.

**St John’s Wort**

St John’s wort is a popular herbal remedy for depression. It is a flower with many chemical compounds, some of which are believed to help depression by preventing nerve cells in the brain from reabsorbing the chemical messenger serotonin, or by reducing levels of a protein involved in the body’s immune system functioning.

Studies have shown that St John’s wort is an effective antidepressant in cases of people with mild non-melancholic depression but ineffective for people with melancholic (biological) depression.

St John’s wort can have side-effects however. There are several reports suggesting that it may have some toxic effects on reproductive functioning. There are other possible problems with St John’s wort, including possible interactions with certain medications.

**Light Therapy**

Light therapy involves exposing someone to bright light for around a half an hour each day. The bright light can be either in the form of conventional fluorescent lamps or bright sunlight.

Light therapy has been shown to have particular benefit for people who suffer from a form of depression known as Seasonal Affective Disorder (SAD), where depression occurs on a regular basis in particular seasons (especially autumn and winter) and then goes away in the alternate seasons (spring and summer). This condition is more common in the northern hemisphere, but it does exist in Australia.
Yoga is an ancient Indian exercise philosophy that provides a gentle form of exercise and stress management. It consists of postures or ‘asanas’ that are held for a short period of time and are often synchronised with the breathing. It is very helpful for reducing stress and anxiety which are often precursors to depression. A number of studies have shown that yoga breathing exercises are beneficial for depression.

Aromatherapy is the use of essential oils to produce different emotional and physiological reactions. There is some evidence that aromatherapy can be helpful in alleviating mental disorders including depression.

Acupuncture is an ancient form of healing developed within the traditional medicine China, Japan and other eastern countries. Acupuncture is based on the principle that stimulation of specific areas on the skin affects the functioning of certain organs of the body.

Fine needles are inserted into specific points (called acupuncture points) just below the surface of the skin. It is believed that acupuncture can help to relieve depression, along with anxiety, nervous tension and stress. A small number of studies support the view that acupuncture plays a valuable role in alleviating depression.

Other self-help measures include:
- Meditation
- Relaxation (See the handout ‘Quick relaxation techniques’ at www.blackdoginstitute.org.au/docs/QuickRelaxationTechniques.pdf)
- Diet
- Alcohol and drug avoidance

The treatment of youth depression has become increasingly specialised and is now recognised as distinct from adult and paediatric treatment models. Adolescence and young adulthood are characterised by rapid physical, cognitive and psychosocial changes, and form not only the peak period for the emergence of mood disorders (Jaffe et al., 2002), but also herald a window of opportunity for early intervention and prevention of long-term negative psychosocial impact and functional impairment. Though supporting data remain scarce, effective treatment of youth depression may assist to decrease relapse or recurrence in later life (Treatment for Adolescents with Depression Study, 2009).

This article outlines the formulation-based assessment and early intervention multimodal treatment model used by clinicians in the Youth Mood Clinic at Orygen Youth Health when working with adolescents and young adults experiencing moderate-to-severe major depressive disorder.

IDENTIFICATION AND ENGAGEMENT

A number of specific approaches have been identified in assessing and treating depression in young people, and practitioners are encouraged to familiarise themselves with the beyondblue (2010) Clinical Practice Guidelines: Depression in Adolescents and Young Adults. While in general depressive symptoms are similar in young people compared to older adults, younger adolescents may be more likely to present with irritability, anger and somatic complaints rather than depressed mood, hopelessness and despair (Verduyn, 2011). Young people may also present primarily with other concerns such as substance misuse, eating problems and academic difficulties, all of which may be underpinned by problems with their mood.

Strategies that facilitate greater access to treatment include flexible hours for appointments, youth-friendly reading material in the waiting room, and text message appointment reminders. Appropriate follow-up of non-attendance should be made without the clinician being overbearing or controlling, leaving open the possibility of future treatment engagement. Defining the therapeutic contract, identifying problems from the young person’s point of view (being sensitive to their vocabulary), collaborative goal setting, and shared decision making and formulation enable clients and clinicians to come to a mutual understanding of the young person’s difficulties (see Verduyn, 2011).

It is important to speak directly to young people and not just to their caregivers; this should begin from the first assessment session, where the clinician interviews the young person alone, and then with the caregiver later in the session or at a subsequent session. Other engagement tips include avoiding the use of jargon, utilising humour where appropriate, and validating attendance and effort.

Issues of stigma, stoicism and poor mental health literacy may also impede engagement, especially for young males. This may be circumvented by taking time to
ASSESSMENT OF SUICIDE RISK AND SELF-HARM IN ADOLESCENTS AND YOUNG ADULTS

Clinicians working with adolescents and young adults experiencing depressive disorders must regularly assess risk of suicide and deliberate self-harm (DSH). Responses to DSH or suicidal ideation should not be punitive. Normalising suicidal or self-harm cognitions as common to those experiencing depression may assist in open discussion, assessment and safety planning. Practitioners can use motivational interviewing techniques to evaluate the pros and cons of DSH coping behaviours and seek to introduce alternative distress management techniques (see McKay, Wood, & Brantley, 2007). Clients should be provided with psychoeducation regarding causes and precipitants of self-harming behaviours and discussion of risks related to wound infection and management, and risk of accidental death by underestimating lethality of overdose (see McCutcheon, Chanen, Fraser, Drew, & Brewer, 2007).

In instances of suicidal ideation and high suicide risk changeability, clinicians may integrate information from risk history and corroborative information provided by others to guide clinical decision making. Consideration should be given to broader psychosocial risk and protective factors, ‘at risk’ mental states, and assessment confidence, and be reassessed regularly, especially in instances of high-risk changeability (see O’Connor, Warby, Raphael, & Vassallo, 2004). Cases of serious concern and high risk will need to be referred to local child mental health or crisis assessment services for crisis follow-up.

establish rapport, normalising depression as a common illness that has both biological and social components, emphasising the high likelihood of favourable treatment outcome and improved quality of life with regular attendance, and linking young people with online peer and professional support communities such as the e-headspace online mental health project (for further engagement tips for working with young people see McCutcheon, Chanen, Fraser, Drew, & Brewer, 2007).

Degree of input and involvement with family members should be negotiated early in treatment, and relevant ethical and confidentiality issues (including limits to confidentiality) should be considered in the context of the mature minor principle.

PSYCHOTHERAPY

Concrete behavioural strategies may be needed for earlier adolescents, whereas older adolescents and young adults may be better able to utilise cognitive interventions (Hollon, Garber, & Shelton, 2005). In addition to supportive counselling, simple interventions for mild depressive presentations for younger clients may focus primarily on behavioural factors, including behavioural activation, mood monitoring, chain analysis, development of problem solving skills, and encouraging activities that promote competence.

In addition to this, for moderate to severe depression cognitive behavioural therapy may be used to identify, challenge and restructure maladaptive automatic thoughts, problematic core beliefs and unhelpful thinking styles. As required, treatment may also focus on managing social anxiety or anger (see Youth Mood Clinic, 2012).

Practitioners may also need to promote client skills in distress tolerance and emotion regulation (including recognition of emotions, relaxation, distraction, acceptance and self-soothing – see McKay, Wood, & Brantley, 2007). Furthermore, elements of interpersonal therapy, focussing on development of communication and social skills, may be useful in assisting young people to establish or re-establish meaningful, supportive and enjoyable peer relationships (beyondblue, 2010). In addition, family therapy may also be indicated, and in such cases practitioners need to be mindful of balancing family sessions with young people’s increased independence and separation from family.

PHARMACOTHERAPY AND LIAISON WITH MEDICAL PRACTITIONERS

The use of antidepressant medication with young people remains contentious, though there is evidence of modest effectiveness, especially in combination with therapy (March et al., 2004). Trialling an SSRI (selective serotonin reuptake inhibitor) should only be considered after discussing the relevant risks (Hetrick, McKenzie, & Merry, 2010), and should only occur within the context of an ongoing therapeutic relationship and management plan (beyondblue, 2010). Close monitoring of response to medication by psychiatrists or GPs is critical given the small but real risk of increases in suicidal thoughts and behaviours at commencement of medication (March & Vitiello, 2009). Psychologists should also liaise with medical practitioners regarding safety planning in instances of escalating risk (see boxed information).

PSYCHOSOCIAL AND VOCATIONAL PLANNING

As increased academic or vocational stress can precipitate depressive symptoms, which can in turn negatively impact academic or work performance, liaison with a young person’s school (or in some circumstances, employer) may be a vital part of treatment. With appropriate consent from the client, practitioners may need to inform school welfare coordinators of progress, risk and safety planning, and modification of school tasks as required. Fostering collaborative relationships with staff at local schools will assist this process. To facilitate ongoing functional gains, planning for termination of therapy and relevant referral to local educational and vocational support services should be undertaken early in treatment wherever possible. Finally, sufficient attention should be given to relapse prevention and wellness planning specifically relevant to young people.
CONCLUSION

Practitioners are encouraged to be mindful of the developmental challenges and changes inherent in working with mood disorders in young people. Treatment approaches that meet clients where ‘they are at’ developmentally and psychosocially will optimise engagement and therapeutic outcomes, and increase the likelihood of functional recovery.

ACKNOWLEDGEMENTS

The authors wish to acknowledge clinicians, past and present, of the Youth Mood Clinic at Orygen Youth Health for providing input into the development of this treatment model. The authors also thank Louise McCutcheon for providing resources on management of risk in young people.

REFERENCES


WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

CONTENTS

BRAINSTORM 52
WRITTEN ACTIVITIES 53
RESEARCH ACTIVITIES 54
MULTIPLE CHOICE 55-56
BRAINSTORM

Brainstorm, individually or as a group, to find out what you know about dealing with depression.

1. **What is depression, and who can it affect?**

2. **What are antidepressants? (Include at least three different types in your answer)**

3. **What does CBT stand for, and how is it used in relation to depression?**

4. **What are ‘talking therapies’, and what are some examples?**
Complete the following activities on a separate sheet of paper if more space is required.

You can’t always identify the cause of depression or change difficult circumstances. The most important thing is to recognise the symptoms and seek help.

Consider the above statement. Form into groups of two or more and make a list of ways to recognise symptoms of depression. Once you have compiled a list of symptoms, brainstorm the potential ways a person could seek help for depression. Compare your findings with other groups in the class.

SYMPTOMS

SEEKING HELP
Complete the following activities on a separate sheet of paper if more space is required.

Research the following treatments for depression. Explain each treatment, including whether or not it is a psychological, medical, lifestyle or alternative therapy; how it is used to treat depression; and how effective it is considered. Include examples and sources to back up your research.

1. Interpersonal psychotherapy

2. Hypnotherapy

3. Electroconvulsive therapy

4. Aromatherapy

5. Light therapy

6. Supportive counselling
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. Which of the following feelings might a person with depression experience? (include all that apply)
   a. Sadness
   b. Joy
   c. Disappointment
   d. Irritability
   e. Excitement
   f. Indecisiveness
   g. Frustration
   h. Lack of confidence
   i. Happiness

2. Which of the following are signs that a person may be depressed? (include all that apply)
   a. Reduced ability to enjoy things
   b. Increase in energy
   c. Suicidal thoughts
   d. Being out of touch with reality
   e. Lowered self-esteem
   f. Change in sleep patterns
   g. Increased productivity
   h. Varying emotions throughout the day
   i. Reduced sex drive
   j. Change in appetite and weight
   k. Improvement in concentration and memory
   l. Loss of motivation and drive

3. Which of the following are considered the main types of depression? (include all that apply)
   a. Major depressive disorder
   b. Arrhythmia
   c. Irritable bowel syndrome
   d. Bipolar disorder
   e. Hypothermia
   f. Cyclothymic disorder
   g. Dysthymia
   h. Seasonal affective disorder

4. Match the following types of antidepressants with their abbreviation.
   a. Noradrenaline reuptake inhibitors
   b. Selective serotonin reuptake inhibitors
   c. Serotonin and noradrenaline reuptake inhibitors
   d. Reversible inhibitors of monoamine oxidase
   e. Tricyclic antidepressants
   f. Noradrenaline-serotonin specific antidepressants
   g. Monoamine oxidase inhibitors
   1. RIMAs
   2. SNRIs
   3. MAOIs
   4. NARIs
   5. TAs
   6. MOIs
   7. TCAs
   8. NSSAs
   9. RIMOIs
   10. NaSSAs
   11. SSRIs
   12. SNaRIs
5. **Respond to the following statements by circling either 'True' or 'False':**

<table>
<thead>
<tr>
<th>Statement</th>
<th>True / False</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telling an adult that a friend is depressed is betraying their trust. If someone wants help they'll get it themselves.</td>
<td>True / False</td>
</tr>
<tr>
<td>b. All young people get depressed; it's just a normal part of growing up.</td>
<td>True / False</td>
</tr>
<tr>
<td>c. Depression can really drain a person of energy and it can have a bad impact on their self-esteem. That means a person with depression may not be able to seek help when they need it.</td>
<td>True / False</td>
</tr>
<tr>
<td>d. All depression needs to be treated with is antidepressant medication.</td>
<td>True / False</td>
</tr>
<tr>
<td>e. Just talking and listening to your friends and family will be enough to treat depression.</td>
<td>True / False</td>
</tr>
<tr>
<td>f. People don’t choose to be depressed. Depression is an illness that is able to be treated with the right help from health professionals. It’s not something that people can just ‘snap out of’.</td>
<td>True / False</td>
</tr>
<tr>
<td>g. People who are depressed need to wake up and get a grip and stop feeling sorry for themselves.</td>
<td>True / False</td>
</tr>
<tr>
<td>h. Sometimes depression can have no obvious cause at all but it may be the result of chemical imbalances in the brain.</td>
<td>True / False</td>
</tr>
<tr>
<td>i. Depression is more serious than just feeling sad. It’s when a person feels a sadness which is so severe it interferes with everyday life, and lasts longer than two weeks.</td>
<td>True / False</td>
</tr>
</tbody>
</table>
Rates of depression are slightly higher in women at some time in their life (Better Health Channel, *Depression: an overview*). (p.1)

Depression can run in families, but this doesn’t mean a person will automatically experience depression if a close relative has had the illness (*ibid*). (p.2)

Drug and alcohol use can lead to and result from depression. Many people with depression also have drug and alcohol problems (*ibid*). (p.2)

Research suggests that behaviour can affect brain chemistry – e.g. long-term stress may cause changes in the brain that can lead to depression. Changes in brain chemistry have been more commonly associated with severe depression than with mild or moderate depression (*ibid*). (p.2)

In the days immediately following birth, up to 80% of women experience the ‘baby blues’ – a common condition related to hormonal changes – but this is different from depression (*ibid*). (p.3)

Up to 1 in 10 women will experience depression during pregnancy. This increases to 1 in 7 in the first 3 months after having a baby (*ibid*). (p.3)

Seasonal affective disorder (SAD) is rare in Australia, and more likely to be found in places with short winter days such as Scandinavia (*ibid*). (p.3)

Melancholic depression affects between 2 and 10% of people who have been diagnosed with depression (ABC, *Fact File: Depression's many shades of blue*). (p.4)

10% of women will experience antenatal depression, but even more – around 16% – will experience depression in the first year after their child’s birth (*ibid*). (p.5)

1 in 5 (20%) Australians aged 16-85 experience a mental illness in any year. The most common mental illnesses are depressive, anxiety and substance use disorder (Black Dog Institute, *Facts and Figures about mental health and mood disorders*). (p.6)

The onset of mental illness is typically around mid-to-late adolescence and Australian youth (18-24 years old) have the highest prevalence of mental illness than any other age group (*ibid*). (p.6)

54% of people with mental illness do not access any treatment (*ibid*). (p.6)

Depression has the third highest burden of all diseases in Australia (13%) and also third globally (*ibid*). (p.7)

Depression is the number one cause of non-fatal disability in Australia (23%). This means that on average, people with depression live with this disability for a higher number of years than people suffering from other non-fatal diseases such as hearing loss and dementia (*ibid*). (p.7)

Mood (affective) problems, which include depression, are most prevalent (2.1 million people or 9.7% of the population) followed by anxiety-related problems (850,100 people or 3.8%) (ABS, *Profiles of Health, Australia, 2011-13*). (p.7)

Rates of depression are slightly higher in women with depression, affecting 1 in 6 (17%) compared to 1 in 10 (10%) men experiencing depression in their lifetime (Black Dog Institute, *Facts and Figures about mental health and mood disorders*). (p.8)

Often there are many interrelated factors associated with depression including inherited disposition, a chemical imbalance in the brain, life stresses, past bad experiences and personality. Medical illness, drugs and alcohol can also play a part (Mental Illness Fellowship Victoria, *Understanding depression*). (p.13)

Australians were almost twice as likely not to tell their boss they are suffering depression, compared to their European counterparts (Grimson, M, *Mental health stigma still affecting Australian workers, with research showing 4 in 10 hide depression from employers*). (p.18)

Beyond Blue estimates that 3 million Australians are currently living with depression or anxiety (*ibid*). (p.19)

1 in 4 young people experience a mental disorder with depression being one of the most common problems (Black Dog Institute, *Depression in adolescents & young people*). (p.22)

There is a range of different treatments for depression varying from counselling and therapy to group and peer support or a combination of these. Antidepressant medication is not recommended for young teenagers. (Women’s and Children’s Health Network, *Young people, feelings and depression*). (p.25)

Most people who are unhappy or diagnosed with depression do not hurt themselves (self-harm) or attempt suicide. But some young people do think about these and act on their thoughts (*ibid*). (p.25)

Antidepressants are often prescribed alongside psychological treatments when a person experiences a moderate to severe episode of depression (Better Health Channel, *Depression – treatment and management*). (p.32)

Doctors estimate that 50-70% of people who have major depression are helped by initial antidepressant medication (myDr, *Antidepressant medicines*). (p.37)

There was approximately a threefold increase in antidepressant prescribing in Australia from 1990 to 1998. The increase reflected what was occurring in most major Western countries and coincided with the widespread introduction of SSRI antidepressants such as Prozac, Zoloft, Aropax and Cipramil during that period. (Mitchell, P, *Are antidepressants over-prescribed in Australia?*). (p.40)

Cognitive behavioural therapy has shown to be effective in reducing the effects of depression for most if not all client groups, including children, adolescents, adults, and older people (AIPC, *Psychological Interventions for Depression*). (p.42)

Studies have shown that St John’s Wort is an effective antidepressant in cases of people with mild non-melancholic depression but ineffective for people with melancholic (biological) depression (Black Dog Institute, *Self-help & alternate therapies*). (p.46)
**GLOSSARY**

**Antidepressants**
Drugs which are prescribed for the treatment of depressive illnesses. They work by boosting one or more chemicals in the nervous system which may be lacking during depression. These include tricyclic antidepressants (TCAs), selective serotonin re-uptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs).

**Anxiety**
A normal feeling people experience when faced with threat or danger or when stressed.

**Anxiety disorders**
When anxiety is so persistent it stops you doing things you want to, or persists even when all logical reasons to be anxious are absent, e.g. generalised anxiety disorder involves chronic worry without a definitive cause, while social phobia involves a fear of talking to or being around others.

**Attempted suicide**
Self-inflicted harm where death does not occur but the intention of the person was to die. There are three types of attempted suicide: without injury, with injury, and a with a fatal outcome (suicide).

**Bipolar disorder**
Once known as 'manic depression', bipolar disorder features both depression and periods of mania interspersed with periods of normal functioning. It is thought to affect around two per cent of the population. **Bipolar I disorder** is when a person experiences oscillating manic (extreme 'highs', often with psychotic features) and depressive episodes. The severity and duration of these episodes are often severe and may result in hospitalisation. **Bipolar II disorder** is when a person experiences oscillating hypomanic (less severe 'highs' with no psychotic features) and depressive episodes.

**Cognitive behavioural therapy**
CBT is a psychological treatment which assumes that behavioural and emotional reactions are learned over a long period. A cognitive therapist will seek to identify the source of emotional problems and develop techniques to overcome them.

**Counselling**
A broad set of approaches and goals that provide problem-solving and learning skills to cope with difficult life circumstances.

**Cyclothymic disorder**
A milder form of bipolar disorder, typically lasting for at least two years.

**Depression**
A mood disorder with prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame.

**Dysthymic disorder**
Essentially a mild but very persistent depression, typically lasting for more than two years.

**Electroconvulsive therapy**
ECT is a physical therapy that may be relevant in a minority of cases of psychotic depression, severe melancholia or life-threatening mania.

**Interpersonal therapy**
A therapy that aims to help people understand how social functioning (work, relationships and social roles) and personality operate in their lives to affect their mood.

**Light therapy**
A treatment that has been shown to be beneficial for seasonal affective disorder and insomnia, where people are exposed to bright light for around half an hour each day.

**Melancholia**
Describes a severe form of depression involving many of the physical symptoms of depression. For example, the person moves more slowly and is more likely to have depressed mood characterised by complete loss of pleasure in everything or almost everything.

**Post-traumatic stress disorder**
PTSD is a form of anxiety disorder in which a person has a delayed and prolonged reaction after being in an extremely threatening or catastrophic situation such as a war, natural disaster, terrorist attack, serious accident or witnessing violent deaths.

**Psychotherapy**
An extended treatment aimed at exploring aspects of the person’s past in great depth to identify links to the current depression.

**Psychotic depression**
The rarest of the depression sub-types. Its most defining characteristics are psychotic symptoms such as hallucinations, delusions and paranoia.

**Seasonal affective disorder**
SAD is a mood disorder that has a seasonal pattern. The cause is unclear, but may be related to the variation in light exposure in different seasons. SAD is characterised by mood disturbances (either periods of depression or mania) that begin and end in a particular season – winter being the most common.

**Self-harm**
When an individual deliberately hurts or mutilates their body without the intent of suicide. There are many different types of behaviours that can be considered self-harming, including self-cutting, self-poisoning and self-burning.

**Suicidal ideation**
Thoughts about attempting or completing suicide.

**Suicide**
The act of deliberately causing one’s own death.

**Transcranial magnetic stimulation**
A treatment that is still under development, but which involves holding a coil near to a patient’s head and creating a magnetic field to stimulate relevant parts of the brain.
Websites with further information on the topic

Better Health Channel  www.betterhealth.vic.gov.au
beyondblue  www.beyondblue.org.au
Black Dog Institute  www.blackdoginstitute.org.au
BluePages  http://bluepages.anu.edu.au
dNet  http://depressionnet.org.au
e-hub Mental Health  www.ehub.anu.edu.au
headspace  www.headspace.org.au
Kids Helpline  www.kidshelp.com.au
Lifeline  www.lifeline.org.au
Mental Health Association NSW  www.mentalhealth.asn.au
Mental Health Australia  http://mhaustralia.org
Mental Health Research Institute  www.mhri.edu.au
Mental Illness Fellowship of Australia Inc  www.mifa.org.au
Mindhealthconnect – Depression  www.mindhealthconnect.org.au/depression
myDr  www.mydr.com.au
Orygen Youth Health  http://oyh.org.au
ReachOut.com  http://au.reachout.com
SANE Australia  www.sane.org
Youthbeyondblue  www.youthbeyondblue.com

ACKNOWLEDGEMENTS
The publisher is grateful to all the contributors to this book for granting permission to reproduce their works.

COPYRIGHT DISCLAIMER
While every care has been taken to trace and acknowledge copyright the publisher tenders its apology for any accidental infringements or where copyright has proved untraceable. The publisher would be pleased to come to a suitable arrangement with the rightful owner.

ILLUSTRATIONS AND PHOTOGRAPHS
Photographs and illustrations courtesy of iStockphoto, except pages 11, 17, 20, 23, 27, 33, 34 and 38 © Simon Kneebone; pages 18, 22, 25 and 50 © Don Hatcher; pages 29 and 44 © Angelo Madrid.

THANK YOU
► ReachOut.com
► Black Dog Institute
► Better Health Channel.

DISCLAIMER
The Spinney Press is an independent educational publisher and has no political affiliations or vested interests with any persons or organisations whose information appears in the Issues in Society series. The Spinney Press seeks at all times to present variety and balance in the opinions expressed in its publications. Any views quoted in this book are not necessarily those of the publisher or its staff.

Advice in this publication is of a general nature and is not a substitute for independent professional advice. Information contained in this publication is for educational purposes only and is not intended as specific legal advice or to be used to diagnose, treat, cure or prevent any disease. Further, the accuracy, currency and completeness of the information available in this publication cannot be guaranteed. The Spinney Press, its affiliates and their respective servants and agents do not accept any liability for any injury, loss or damage incurred by use of or reliance on the information made available via or through its publications, whether arising from negligence or otherwise.

This e-book is subject to the terms and conditions of a non-exclusive and non-transferable SITE LICENCE AGREEMENT between THE SPINNEY PRESS and: Trinity College, East Perth, library@trinity.wa.edu.au
INDEX

A
acupuncture 36, 47
adolescents see young people
alternate therapies 36, 46-47
antenatal depression 3, 5
antidepressants 13, 17, 28, 29, 32, 36, 37-39, 40-41, 49
types of
monoamine oxidase inhibitors 37, 38
noradrenaline reuptake inhibitors 37, 38
noradrenaline-serotonin specific antidepressants 37, 38
reversible inhibitors of monoamine oxidase 37, 38
selective serotonin reuptake inhibitors 37, 38
serotonin and noradrenaline reuptake inhibitors 37, 38
tricyclic antidepressants 37, 38
anxiety disorders 12
appetite, changes in 14, 21
aromatherapy 36, 47

B
behavioural symptoms 1, 14-15
behaviour therapy 43
bibliotherapy 36, 46
bipolar disorders 3, 5, 11-12, 32
prevalence 7-8

C
cognitive behavioural therapy (CBT) 15, 28, 36, 42, 44, 49
congestion, impaired 14, 22, 27
counselling 28, 29, 36 see also psychotherapy
cyclothymic disorder 3, 5, 32

D
depression
atypical 5
causes of 1-2, 4-5, 9-10, 13
biochemical factors 9
brain, changes in 2, 9-10
gender factors 10
genetic factors 9
physical illness 9
coping with 32-34
definition of 13
diagnosis 30, 31
drug and alcohol use and 2
duration of 28
family history and 2
life events and 2
severity of 11, 30
facts and figures 6-8
management of 32-34
medical illness and 2
mild 13, 30
misunderstandings about 16-17
moderate 13, 30
negative thoughts and 1, 33
personality and 2, 10
prevalence 6-8, 32
recovery from 13-15, 32-34
severe 13, 30
symptoms of 1, 4-5, 14-15, 21-22, 27, 30, 31
types of 2-3, 4-5, 32
dysthymia 3, 5, 32

E
electroconvulsive therapy (ECT) 15, 28, 36
employers 18-19
enjoying activities 33
exercise 36

F
fatigue 14, 33-34
feelings
caused by depression 1
dealing with 23

G
general practitioners (GPs) 22, 28-29, 49

H
help
behaviour towards someone who is depressed 17, 29
family and friends 15
friend with depression 20
parents, how they can 23-24
seeking 2, 22, 24, 27, 28-29, 32, 34
hospitalisation 13-15

I
interpersonal psychotherapy 28, 36, 42
interventions see treatments
irritability 33-34

L
light therapy 36, 46

M
major depressive disorder 2, 13, 32
mania 3, 11
manic depression 3, 32 see also bipolar disorders
marital therapy 43
massage therapy 36, 47
medication see antidepressants
melancholia 3
melancholic depression 4-5, 11
men 10, 32
mental disorders
gender differences 8
prevalence of 6-8, 21

N
non-melancholic depression 4, 11

O
omega-3 (fish oil) 36, 46

P
parents 23-24, 25-26
perinatal depression 8
phototherapy 34
postnatal depression 3, 5
problem-solving therapy 43
psychiatrists 28, 29
psychologists 28, 29, 49
psychosocial planning 49
psychotherapy 28, 29, 36, 42, 43, 44-45, 49
psychotic depression 3, 5

S
school counsellors 22, 49
seasonal affective disorder (SAD) 3, 5, 32, 34
self-assessment 31
self-harm 25
self-help 46-47
sex drive, reduced 15, 22, 27
sleeping patterns 15, 21, 27, 33
St John’s wort 36, 46
stress 10, 49
suicidal ideation 14, 27-28, 49
suicide 6-7, 22, 25, 41, 49

T
talking therapies 44-45 see also counselling, psychotherapy
transcranial magnetic stimulation 28, 36
treatments 13-15, 28, 29, 32-34, 35-36, 42-43
lifestyle 36
medical 36
physical 28
psychological 13, 28, 32, 36, 42-43, 44-45
rating system 35-36
scientific evidence for 35-36
young people 48-50

V
vocational planning 49

W
women 3, 5, 10, 32
workers 18-19

Y
yoga 36, 47
young people 16-17, 21-22, 23-26, 48-50