From Depression to Happiness

From Depression to Happiness:

A Positive Psychiatry Prescription for Life after Depression

By

Erick Messias

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Dedication

My students, who have taught me so much.
My patients, who have cared for me so many times.
This book is for you.

To Pedro & Ivonele: deep roots
To Janilson, Ivan, & Anna: luminous fruit
To Nidia: strong core

The information provided in this book is designed to provide helpful information on the diagnosis and treatment of depression. This book is not meant to be used, nor should it be used, to diagnose or treat any medical condition. For diagnosis or treatment of any medical problem, consult your own physician. The publisher and author are not responsible for any specific health needs that may require medical supervision and are not liable for any damages or negative consequences from any treatment, action, application or preparation, to any person reading or following the information in this book. References are provided for informational purposes only and do not constitute endorsement of any websites or other sources. Readers should be aware that the websites listed in this book may change.

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INTRODUCTION

HOW THIS BOOK CAN BE USED

If you think you have depression, please close this book and get treatment now. If someone you care about has depression, please help them get treatment as soon as possible. The aim of this book, including the chapters specifically about depression and its treatment, is not to stand by itself as a self-help book or a tool that aims to treat depression but to act, instead, as a complement to your treatment with a mental health professional. Working in mental health, we have a variety of professionals ranging from psychologists to social workers, from psychiatrists to nurses, and from counselors to primary care physicians. These professionals can help you immensely and you should not delay care by pondering how to exactly match each professional category for your specific immediate needs. Any good mental health professional will be able to direct you to another type of professional in the team, if and when you need a different type of care.

The Two Parts of One Book

The journey is what matters and it is always punctuated by where it starts and where it ends. On each journey, one leaves a place behind, while aiming to reach a destination that lies ahead. It is not different in a book like this. The path mapped in this book goes from depression (the place we want to leave behind) to contentment (the destination we all aim to reach). With this in mind, Part 1 of this book is designed to be a companion to depression treatment; it has the type of information I wanted my patients to have so that they could take full advantage of their treatment. It also serves to address many questions that patients have but which they can only have the time to ask and find the answer after stitching together a long quilt of short appointments. An inescapable reality of psychiatry, as it is practiced today, is that we have short visits and long wait times. Part 1 then is a

companion to treatment that hopes to speed recovery, foster resilience, and prevent relapses. This is the part that I am familiar with, as I have trained and practiced this for many years. If in Part 1 we deal with a subject that psychiatrists have been pondering for the last 200 years, then in Part 2 we venture into the other territories that psychiatrists need to consult with in the form of Positive Psychology and philosophy. Indeed, they have been pondering this for the last 2000 years and so we will talk about happiness, contentment, and the Good Life. As I saw my patients getting out of the depths of depression, the question that would mark their recovery was "what should I do now that those depressive symptoms are under control?" This is a reframing of the eternal question of what is it that makes us happy. Unfortunately, there is not much of an answer in psychiatry. Fortunately, the answers to those questions have been explored for over two thousand years by philosophers and currently by a branch of psychology known as Positive Psychology. In Part 2, we will learn about happiness and the Good Life by examining a fundamental book for our human civilization, *Nicomachean Ethics* (pronounced "Neo-McKeon"), where Aristotle, who is arguably the most influential thinker of all times, states that "happiness is an activity of the soul in accordance to virtue and excellence". Part 2 will show us that this strong and counterintuitive argument made at the dawn of our civilization still resonates in the findings of Positive Psychology today. This is one psychiatric pill that should complete the treatment of depression, which just happens neither to be a pill nor to come from psychiatry.

I wanted to help my patients not only to get the most out of our depression treatment but also to work on their own personal happiness project as they reach remission from depressive symptoms. This is because I do not believe that depression is just a lack of happiness and, instead, I consider it to be a state of profound hopelessness, deep sadness and, at times, one of paralyzing fear, which is generated by the misfiring of brain regions associated with emotional control. I do not know—and, in fact nobody does—if these alterations, which I call misfiring, are caused by a bad combination of genes, a "chemical imbalance", or by severe longstanding stress. However, the final product and the common denominator of these processes is likely to be some misfiring of

neurons that constitute the brain regions associated with emotion generation and control. Thus, it requires our standard treatments for depression, which include talk therapy (psychotherapy) and medications (antidepressants), among other measures.

I also do not believe that happiness is the absence of depression. Happiness is not even the opposite of depression. The opposite of depression is mania, which is its opposite pole in the bipolar disorder diagnosis. Happiness is a state of being that takes effort and a purpose. The second part of this book is dedicated to using Aristotle's ideas about happiness from books and lectures he gave over two thousand years ago and combining them with their counterparts in our contemporary neurosciences, brain pathophysiology, and psychology. This bridge between the work needed to overcome depression and the steps needed to achieve happiness is the glue that keeps this book together. We all need Part 2 because, to use the words of Thomas Jefferson, we are all in pursuit of happiness; indeed, Jefferson was also influenced by Aristotle's *Nicomachean Ethics*, as evident in the Declaration of Independence. Some of us, or someone we love, will also need Part 1. As a psychiatrist, I have met and worked with many such people, and this book is to show they are worth more than antidepressants and that they also deserve happiness.

So, if you are among those with depression then, after you have seen a professional and started treatment, this book should help you understand where your treatment is heading and help you to anticipate what you should expect. Going beyond the standard treatment for depression, I would like to add a discussion on happiness to this conversation, including what we know about this and how to create what has been called "a Good Life". In fact, if you are satisfied with how your treatment is going and you have had a chance to discuss these issues with the professional who is working with you, then you may actually skip Part 1, where we discuss this diagnosis and the medical treatment of depression, and move on to Part 2, so you can start working on being happy again.

Disclaimers from a Profession at War: The false dichotomy of Biological Sciences vs. Humanities in Psychiatry

As much as I am writing this book with my patients in mind, I have to disclose a serious issue that lurks between the lines of this book. While this book is not intended to address our complex professional standoff, I have to give you a brief overview of the battle raging at the heart of psychiatry today. This painful reality creates an underlying mission for this book: to serve as a bridge between two warring factions that have philosophy and social sciences on one side and biological psychiatry and neurosciences on the other.

Throughout the history of psychiatry, there has always been a tension between the humanities aspects of psychiatry and care for the mentally ill versus the medical, and particularly neurological, aspects of mental disorders. These two camps have alternated positions as the dominant paradigm in psychiatry and, currently, mainstream psychiatric thinking is certainly on the side of the medical approach, which is informed by neuroscience: a new scientific way of understanding the brain and the nervous system. This debate has led to increasingly more virulent attacks from both the social sciences and humanities professionals, such as anthropologists and philosophers, against psychiatry. Examples of such criticism include the antipsychiatry movement in the 1960s and today's "critical psychiatry" approach. Recent critics, following the path opened by Thomas Szasz, include Ben Goldacre, James Davies, and Daniel Carlat, who is also a psychiatrist like Szasz before him. As a psychiatrist, it pains me to see such articulated attacks on my profession and it is even worse to have to admit that they do have some merit. Over the last few decades, there has been an emphasis on neurosciences as the Holy Grail that will explain away all our human sorrows, although currently this hope is shifting from neurosciences to genetics. This picture is compounded by the influence of a multibillion-dollar industry: the pharmaceutical companies whose products I have prescribed and which have saved the lives of many. This fact is quite evident in the field and it is also, at times, quite demeaning. So, the critics do have a point; actually, they have many good points. What I cannot allow is to see the baby of psychiatry be thrown out with the dirty bath water of academic hubris and industry greed.

On the philosophy front, there is a movement known as "clinical philosophy" or "Practical Philosophy", which aims to use philosophy as psychotherapy or counseling. I welcome these philosophers to our efforts and deeply enjoy their questions, their discourse, and their discussions; however, what I do have a problem with is the devaluation of psychiatry and neurosciences that sometimes follow suit. I do hope we can have a dialogue where we can learn from each other's perspectives and help our patient even more. As an example, one of the best-known books on clinical philosophy is a very useful short guide written by the practicing philosopher, Lou Marinoff, and smartly titled, *Plato not Prozac! Applying Eternal Wisdom to Everyday Problems*. If anything, I am responding to his challenge with this book by tackling both perspectives: in Part 1 by explaining some of the neuroscience background and practice of psychiatry, and how it can help get people out of the misery of depression; and in Part 2 by using philosophy, with help from psychological research, to move from the remission of depressive symptoms to achieving happiness. So, this little book of mine could be called *Plato AND Prozac!* or maybe I should actually say, *Aristotle and Abilify!*

A second disclaimer related to the profession comes from being a physician and, in particular, as someone who is of a "psychiatry persuasion". Having practiced medicine for over 20 years, I have seen a great deal of pain, suffering, and bloody wounds; I mean this quite literally. The practice has also showed me the healing powers of the human body and its many amazing organ systems. Having practiced psychiatry for over 15 of those 20 years, I have seen an incredible share of unstable moods, maddening hallucinations, dysfunctional relationships, and a huge amount of alcohol and drug consumption. I have seen people overcome tragedy and trauma in the most unsuspecting places.

With regard to the amount of pain, physical and mental, that I have witnessed as physician and as a psychiatrist, I can attest that there is an immense level of suffering in the world today. I can also tell you people can change; in fact, I started in psychiatry believing everybody can change and I still believe most can. So, changing one's level of suffering may not be easy but it is possible. And I am saying this because I have also seen the power of resilience and the force of the

human body and mind, or spirit. If happiness was easy, then there would not be shelves of self-help or self-improvement books available and mental health clinics would not have waiting lists.

A physician who feels that he has learned a great deal from the imperfect practice of psychiatry writes this book. I will also be honest with you because one of the many lessons my patients have taught me is to not sugarcoat things because these are real people, with real problems, and real brains, and it is not all in the mind.

An Itinerary: How this book is organized

The path *From Depression to Contentment* is organized into ten chapters. Chapter 1 deals with the definition of depression, explaining the current diagnostic clues that have to be assembled by a mental health professional in order to reach this diagnosis. While it is important to know what depression is, it is also essential to understand what depression is NOT: character flaws, laziness, and, especially, other medical conditions that may mimic the symptoms of depression. These misconceptions feed on the problem of stigma against mental disorders and the impact of this will be shown as well.

In Chapter 1 we will also point out some relevant scientific findings we know today about depression: how common it is, what we know about some of its genetic underpinnings, and which brain areas are thought to be associated with it. As fascinating as these neuroscience findings can be, this approach is still in its infancy and there is a lot to be learned. Chapter 2 will address the basics of depression management and treatment. There are many types of antidepressant medications, as well as a number of validated modalities of psychotherapy. In Chapter 2 these medications, along with their most common side effects, are listed while also addressing some others that may help with depression even if they are not strictly classified as antidepressants. The role of herbal, alternative, and other modalities of treatment (such as light therapy and physical activity), is briefly discussed. After examining the basics with regard to diagnosis and treatment, we will then get to know Aristotle's ideas on happiness and achieving the Good Life in Chapter 3; here, you will also find a short background on the philosopher and his extensive influence on many areas of our daily

lives even to this day. Chapter 3 introduces Aristotle's most influential book, *Nicomachean Ethics*, and his definition of happiness as an *Activity of the Soul in Accordance to Virtue and Excellence*. Chapter 4 follows with our first bridge: from Aristotle's concept of externals to Abraham Maslow's hierarchy of needs. After crossing that bridge, we will find ourselves in Chapter 4 where we will discuss the definitions of human excellence and move from Aristotle's, at times, narrow take to a broader perspective informed by Howard Gardner's Multiple Intelligences Theory, which was proposed in the 1980s. Multiple Intelligences Theory updates Aristotle's view and allows for a more inclusive concept of human excellence, and this is our second bridge. Chapter 5 will concentrate on the concepts and applications of virtue taking Aristotle's *Doctrine of the Mean* as a starting point and then move on to a recent effort by Martin Seligman and Christopher Peterson to identify a set of universal human virtues and character strengths. The concept of *Flow*, also known as the psychology of optimal experience, will be at the center of Chapter 7. The eight elements thought to be associated with optimal experience are described and exemplified to help identify and achieve this state. Chapter 8 will address Aristotle's insight into the importance of habituation and relate that to current findings on the psychology and neuroscience of habits. Chapter 9 deals with the role of meaning in life by creating a sense of a life worth living. In this chapter, we attempt a bridge from Aristotle's concept of Telos to Susan Wolf's meaning in life perspective. Finally, in Chapter 10 we will look for ways of applying all of this to our daily electronically rich and technologically inundated lives. In each of these chapters, I will bring up real examples of those principles in action today. For the most part I try to do so using local examples, like a farmer's market for the Good Life.

Using home-grown examples

As we cross these many bridges you will encounter a number of people exemplifying the points discussed. In Part 1, I illustrate aspects of depression diagnosis and treatment using an example from my clinical practice. As is common practice in psychiatry and medicine, to protect the patient's confidentiality I have changed some aspects of a case so as to make identification impossible, without modifying its

fundamentals. As for Aristotle's recommendations, I have also illustrated each with some concrete examples of such recommendations in action; for those examples, I have provided full names and I have interviewed each of the individuals described and I have seen them in action. When one starts with someone of Aristotle's stature, it is easy to go forward with examples like someone who has conquered the Everest, or rowed across the Atlantic, or who has been in outer space. These are great examples of human achievement and they are inspirational. Additionally, I have had great pleasure in listening to their speeches as they try to connect their extraordinary experiences with our mostly ordinary lives. But then, these are indeed extraordinary experiences. We, the rest of us, live ordinary lives and it is a sad commentary that the word "ordinary" has acquired the meaning of uninteresting or commonplace, when in fact it also means a regular or customary condition, or the course of things. The argument and hope of this book is that happiness need not be extraordinary. Happiness, so defined, should be an achievable goal for us all, and should not be seen as an extraordinary event belonging to the chosen few. I believe that, given the minimal set of supportive elements that Aristotle called Externals, happiness is achievable and a Good Life is possible for the vast majority of us.

So, my examples are people I have met right here in Little Rock, Arkansas. These are people I know and I have seen elements of what Aristotle described over two thousand years ago in them. None of them has conquered Everest; although one has tracked the Appalachian Trail. None of them has rowed the Atlantic; although one has been in the Paralympic swim team after becoming quadriplegic. None of them has spent time in outer space; although one still volunteers his time at the age of seventy-five. In sum, none of them has the outside badge of an extraordinary superhuman but, in their everyday life, they display some of the elements of the Good Life as described by Aristotle. So, I talked to each one for this book and listed them as my exemplars. I hope this book will also open your eyes to those around you that are spending their time wisely building the Good Life for themselves and others. Look carefully; they are all around you.

Why Little Rock? Exactly to show that you too should be able to find examples of happiness, excellence, virtue, and human dignity, wherever you are. I happen to live in Little Rock, so I look for it here. If you are in New York City, or Fortaleza, or Cape Town, or Manila, or any other human gathering you should be able to find these examples. I want you to know some people I have met here so you can find your own examples wherever you live and follow their lead.

Happy lives should not be the exception; we should all strive to be happy.

Finally, in one of his early works on psychotherapy, collected in his *Selected Works on Hysteria*, the great psychiatrist Sigmund Freud declares, "Much will be gained if we succeed in transforming your hysterical misery into everyday unhappiness". As much as I agree with the need to free people from the depths of depression, I propose we strive to do better than accept everyday unhappiness; so, I will offer you this modest tome that bridges two perspectives: the first devoted to combating the hysterical misery of depression, and the second aiming for a much higher goal, the path towards happiness, contentment, and the Good Life. Safe crossings!

PART 1

FROM DEPRESSION TO RECOVERY

"Depression is the worst disease you can get. In every disease you want to get better. In Depression you want to die."

—Told to me by a patient many years ago.

CHAPTER 1

THE DIAGNOSIS OF DEPRESSION: WHAT YOU NEED TO KNOW

Major Depressive Disorder is a medical problem and if you have a medical problem it naturally follows you should seek medical care as soon as possible. In mental health, that first step may be complicated by the number of different professionals involved: from social workers to psychologists; from psychiatrists to advanced practice nurses. All of these different points of entry may generate confusion and doubt. Unfortunately, for some people this wide array of choice turns into an excuse to avoid getting treatment. Do not do that! And do not let your loved ones fall into this trap as this will just delay potentially life-saving treatment. Any good professional in any of these areas can help you and, as a practicing psychiatrist, I have known and worked with some great psychologists, wonderfully-skilled social workers, and outstanding nurses. Be sure to remember that these trained professionals should also be prepared to know the limits of their own practice and training, and will be able to refer you to another type professional if that is what is needed. So, a good psychologist will know when you need medication that a psychiatrist can prescribe and a well-trained social worker will know when you need to have a physical check-up to rule out medical causes for your symptoms. As a psychiatrist, I refer people to therapy every day, when most of them have come to my office in search of a miracle drug because they know I am a psychiatrist, "and shrinks prescribe medications". I have also received patients from psychologists and social workers when they were not doing well with therapy alone and helped them by starting a medical treatment that focuses on specific depressive symptoms amenable to medication. Mental health is a team sport; there is no question about that. And the game starts with a comprehensive evaluation, which leads to a correct diagnosis. A

comprehensive evaluation usually takes more than one visit and often more than one professional, which indicates the need for collaboration and integration within mental health categories and across medical specialties.

I have seen many people with depression in fifteen years of psychiatry: depression in those that are destitute and homeless; depression in people that had beach homes in Florida and California; depression in women as well as men; depression in people from Japan, Austria, Brazil, Korea, China, and, in the US, I have seen depression in people from Baltimore to Augusta to Little Rock. Depression does not discriminate. In every case, the earlier you get treatment the better the outcome. Depression also presents in many disguises and, if anything, practicing psychiatry has made those famous lines the Russian novelist, Leon Tolstoy, uses to open his great novel *Anna Karenina* very real to me: happy families are all alike; every unhappy family is unhappy in its own way.

During these years of clinical practice, I have tried to answer the questions patients put to me while sitting at the office. I have heard some of these questions many times, and over the years I have seen how the answer to them can make a difference. As I heard the questions time and again, I always wished there was a book I could share with them. First, the answers on its diagnosis and causes are presented and in the following chapter we will discuss treatment and management. It is organized so that we will address them carefully, articulating what we know, admitting what we do not know, and providing a good summary of how to go about the diagnosis of depression. To start, let me introduce you to a patient of mine.

Little Rock example: Diagnosing depression

I remember when Nadine came to my office in the spring of 2012. The words of poet T.S. Elliot in *The Wasteland* rang true in her: "April is the cruelest month". She had the slumped shoulders of a tired athlete and the fidgetiness of a five-year old. She was tired but could not rest; she was restless but could not accomplish much; she felt anxious and afraid but did not know why and of what. From the outside she possessed the elements of a Good Life: she had a loving

and caring husband, she had small children under her care, she had a business herself that was "doing pretty well", and she had a supportive extended family and a large group of friends. Yet she was miserable. Her appetite was erratic: at times eating too much, while at other times not caring to eat at all. Her sleep habits followed a similar pattern: at times having sleepless nights, while at other times not being able to get out of bed for days. She was tearful and nervous. Her condition was starting to get in the way of her marriage, since she could not enjoy sex and had no energy or interest in trying it. Her kids needed attention she could not provide; her friends called her but got little response. Old energetic and upbeat Nadine was gone, and had been replaced by a slow moving, restless, and moody new Nadine.

She had been treated by another local psychiatrist for about two years and was being prescribed a combination of Ziprasidone (an antipsychotic better known as *Geodon*), Lamotrigine (a mood stabilizer also known as *Lamictal*), Lysdexamfetamine (a stimulant approved for attention-deficit disorder under the commercial name of *Vyvanse*), and Zolpidem (the widely used sleep-aid *Ambien*). With that cocktail of medication, I could see a fellow psychiatrist was trying his best to address the plethora of symptoms described by the patient and was clearly not succeeding given the unusual, if not chaotic, combination of different medications from multiple classes that had been approved for many indications. In psychiatry, when facing a poor response to one treatment associated with one diagnosis we tend to think of co-occurring conditions; in this case, her psychiatrist was considering bipolar disorder and attention-deficit disorder (ADD) as possible co-occurring conditions which, therefore, complicated both the presentation and its treatment. Additionally, at some point, she was also diagnosed with post-traumatic stress disorder, commonly known as PTDS, and one therapist suspected she was drinking more than she admitted to and was possibly an alcoholic.

The more I talked to Nadine, the more I thought that I was facing a presentation of severe treatment-resistant depression, without the required manic episodes to justify an extra diagnosis of bipolar disorder or the attention symptoms required for adult ADD. So, we agreed to slowly take her off the antipsychotic and stimulant medications. She did not have the history of trauma required for a

diagnosis of PTSD and she was not drinking alcohol or using drugs to justify the extra diagnosis of substance-induced mood disorder. On that initial visit on April 2012, I also ordered a series of screening blood tests to exclude medical causes of depression, such as thyroid dysfunction, cholesterol and lipid profile, vitamin levels, syphilis, kidney and liver functions, and a complete blood count. They all came back normal.

At the time of her assessment, Nadine was not seeing a therapist. Like the vast majority of patients I see with depression, I strongly recommended that she should start therapy, which she was initially skeptical about but she reluctantly agreed. With the first measures in place, we were ready to focus on the issue of depression itself. Nadine is a good example of how depression can present with many different masks and disguises.

Now, let us go over the underlying principles of depression diagnosis and map why the diagnosis was given, what it means, why we needed that blood work, what could possibly be causing it, and what could be going on in Nadine's brain.

What depression IS

Depression is a broad category, which includes many maladies. Depression is understood today as medical condition that can cause psychological and physical symptoms. Its official name is Major Depressive Disorder, which is abbreviated as MDD. It usually manifests as extreme sadness, or the loss of interest or pleasure for at least two weeks, along with other symptoms, such as changes in sleep and appetite, energy levels, and ideas of worthlessness and guilt. These symptoms may be organized as psychological symptoms (depressed mood, loss of interest, thoughts of death, and of worthlessness or guilt); physical—or somatic—symptoms, sometimes known as vegetative symptoms (changes in sleep, appetite, restlessness, and decrease energy); and cognitive symptoms (like changes in concentration). In order to be diagnosed with a major depressive episode a person needs to have at least five of these nine possible symptoms and one of these symptoms needs to be either depressive mood or a loss of interest or pleasure. A person may have a single

episode but a recurrent pattern, with multiple episodes throughout their lifetime, is much more common.

There are other depressive disorders besides Major Depressive Disorder within the chapter on depressive disorders in the official diagnostic manual for American psychiatry. In this book, the general term depression is used in reference to a number of conditions that share an affective—meaning emotional—core. When we deal with information specific to Major Depressive Disorder it will be noted and references to the larger group of depressive disorders will be referred to using the general term, depression. In psychiatric practice, our main reference on how to diagnose mental disorders is a heavy medical textbook called the *Diagnostic and Statistical Manual*, which is published and updated periodically by the American Psychiatric Association. The current edition, its fifth main revision, was released under a flurry of controversy in May of 2013 and is referred to in our profession as the DSM-5. The controversies included changes in how mental disorders are diagnosed and how these changes could affect how common they are; an example of these changes was the creation of a new diagnosis named Disruptive Mood Dysregulation Disorder or DMDD for short. By adding a new diagnosis, the DSM-5 flirted with making a disease out of childhood behaviors that were previously considered within normal limits. Decisions like this led to numerous debates about the wisdom of the review process and the influences of different groups—lobbyists for big pharma included—in pushing the creation of diagnoses, or markets. This is one example of the many controversies described in books like *The Loss of Sadness*, *The Book of Woe*, and *Saving Normal*—this last one was written by the chief editor of the DSM-IV, Dr. Allan Frances. According to this official nosology guide, the following disorders are included within the depressive disorders chapter along with Major Depressive Disorder:

Disruptive Mood Dysregulation Disorder is a brand-new disorder that was not recognized until the current revision and was proposed to help diagnose mood problems with underlying temper outbursts in children aged six to eighteen. This new diagnosis was created to provide an option for clinicians caring for children with longstanding irritability problems, who have erroneously received the diagnosis of

childhood bipolar disorder and been prescribed antipsychotic medications.

Persistent Depressive Disorder (also known as dysthymia) presents with depressive episodes that last much longer, sometimes for years, than those associated with the usual major depressive disorder.

Premenstrual Dysphoric Disorder (PDD) is a controversial diagnosis only now officially added to the psychiatric nosology. This is the notorious premenstrual syndrome or "PMS", which is also known as premenstrual tension. Among the symptoms of PDD are affective lability, also known as mood swings, irritability, depressed mood, and marked anxiety. These symptoms are usually associated with decreased interest, difficult concentrating, feeling tired, changes in appetite and sleep, a sense of being out of control, plus physical symptoms like breast tenderness, joint pain, a "bloating" sensation, or weight gain. This set of symptoms usually appears in the week before the onset of menses and begins to improve within days of its start, and is minimal in the week post-menses.

Substance or Medication Induced Depressive Disorder occurs when a medication or drug causes depressive symptoms. There are several well-documented instances where medications cause depression, and it is in fact listed as a side effect of several medications. Some of the medications most commonly associated with depression are:

- Opioids: the class of medications used for chronic pain.
- Steroids: including medications like prednisone, which is used to treat a variety of medical conditions. Patients may develop a complicated form of depression known as psychotic depression, and its severity is such that one can end up suicidal after beginning treatment.
- Interferon: this is a medication used for the treatment of hepatitis. Depression is so commonly associated with interferon treatment that some recommend using preventive antidepressants before starting treatment.

- Even some medications commonly prescribed to treat common conditions, such as high blood pressure, may also cause depressive symptoms.

Depressive Disorder Due to Another Medical Condition occurs when the depressive symptoms are actually the result of another disease. A number of medical conditions may cause depressive symptoms and should be investigated. The main reason for this is that these medical conditions need treatment themselves, and there are usually effective treatments available. Some examples I have seen in my own practice include patients with thyroid disease, who in fact, usually needed an endocrinologist, rather than a psychiatrist; patients with Lyme disease, who needed antibiotics, not antidepressants; and patients with vitamin deficiencies, who actually needed vitamin supplementation. So, these medical conditions should be investigated in a comprehensive assessment for a patient with depression. Here are some examples of medical conditions associated with depressive symptoms (this is not an exhaustive list, so again, seeing a competent professional is the way to go):

- Neurological disorders, like Parkinson's disease, multiple sclerosis, and Alzheimer's.
- Infectious diseases, like syphilis, HIV/AIDS, and Lyme.
- Cardiac disorders, like cardiac failure, ischemic heart disease, and cardiomyopathy.
- Endocrine diseases, like hypothyroidism, diabetes, vitamin deficiencies, and parathyroid diseases.
- Inflammatory disorders, like irritable bowel syndrome, fibromyalgia, and chronic liver or kidney diseases.
- Neoplastic disorders/cancers, like tumors in the central nervous system, as well as pancreatic cancer.

We also know that the opposite can also happen: that is, depression may increase the risk of having other medical conditions. So, several studies following those with depression showed an increased risk of illnesses, such as diabetes, stroke, dementia, and heart disease. Currently, it is not clear if depression raises the risk of some medical conditions or some medical conditions raise the risk of depression; it

is likely either could happen, depending on the person. A take-home message here is that having depression increases the odds of being medically sick and, for those that are medically sick, they are more likely to experience depressive symptoms.

Another important lesson we learned from following people with medical conditions over time is that, compared to those without depression, those with depression seem to do worse. So, for example, in persons suffering a heart attack, those also having depressive symptoms in its aftermath are more likely to have a second heart attack. It follows that depression not only hurts you mentally, thereby affecting your relationships, family life, and work, but also affects your body in a serious, and even lethal, way.

Major Depressive Disorder also has a number of subtypes. These are the many ways in each the disease will present. This is different from the most common presentations of depression and we can identify them as emerging from different causes.

- Major depression with atypical features—in contrast to the usual decreased appetite and insomnia seen in most cases, these are people with depression who present with increased sleep, increased appetite, and they also tend to be very sensitive to rejection.
- Seasonal Affective Disorder (depressive disorder with a seasonal pattern) —recurrent major depressive episodes in a seasonal pattern, usually in the winter. This pattern was first observed in places with cold and long winters, when the days are very short and there is little exposure to sunlight. Since the first descriptions of these cases, emotional responses to changes in the environment cases have been reported even in places with limited seasonal changes. I saw a patient once whose main disappointment in life was not making it to the big league after playing on little league for years. For him, every year at the start of his sport's major season acted a reminder, thereby triggering a depressive response. Another intriguing facet of seasonal affective disorder is that it may be treated quite well with light therapy but only when it is linked to changes in sunlight exposure in winter months. I have