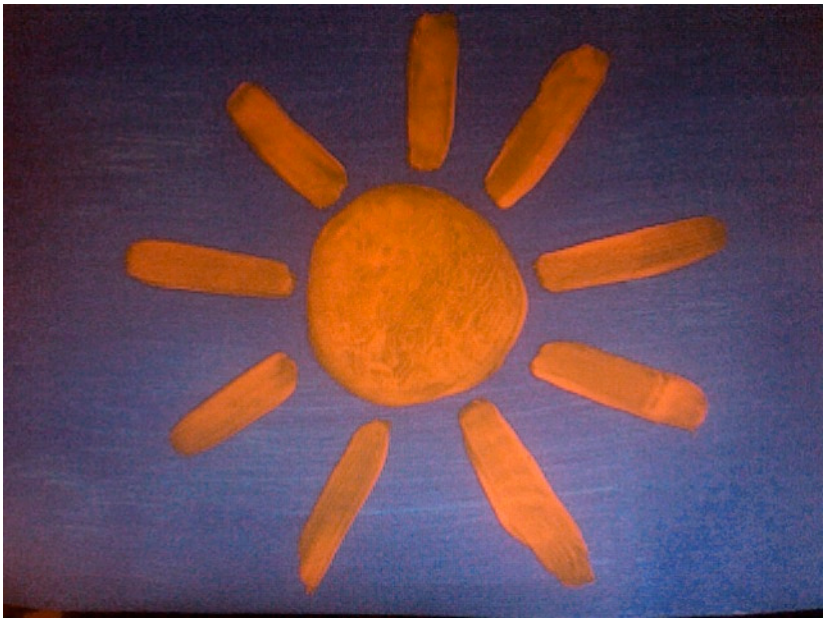
DEPRESSION:
What You Know Can Help You



International Perspectives on Depression for People Living with Depression and Their Families

An International Awareness Packet
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This international mental health awareness packet was supported by an unrestricted educational grant from WYETH Pharmaceuticals which had no control over its content.

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INTRODUCTION

Depression is one of the leading causes of disability across the world. The World Health Organisation (WHO) estimates that depression will rank second only to heart disease by 2020 in terms of global disability. It is a common, serious and complex illness that affects an estimated 121 million people worldwide.[i]

Depression is a disorder of the brain. Men, women and children can develop depression. The exact cause of the disease is unknown, but it is thought to be a combination of genetics and life experiences.

People living with depression generally need some form of treatment to get better. There is no cure for the disorder, but there are many effective treatments, including medications and talk therapy. In many parts of the world, these treatments are not available. In many cases, traditional healers are sought to ease the burden of the disorder. But more often, depression goes undiagnosed and untreated. Without treatment, the symptoms can last for weeks, months or years.

There is significant stigma associated with depression across the globe. People often believe that depression is a sign of weakness or laziness. Educational and outreach programs worldwide are working to change these perceptions and to help people better understand this serious illness.

This packet will provide you will information about depression, the signs and symptoms of the disease, the types of treatment and resources for finding help.

WHAT IS DEPRESSION?

Many people have days or even weeks that go by when they may be feeling down, unhappy or even depressed. People often talk about having the "blues." But unlike the blues, depression doesn't just go away. It usually gets worse.

Depression is a serious medical condition that affects the body, mind and behavior. It affects the way you eat and sleep, the way you feel about yourself, the way you think about things. It can also affect your physical health.

Depression is a brain disorder that can affect people of all ages, races, religions, and incomes worldwide. Depression can come in many forms, with varying symptoms and experiences with the illness.

Depression Facts

- Depression affects people of all ages, races, religions and incomes worldwide.
- Depression is not a sign of weakness or a defect in character.
- People with depression cannot get better simply by "pulling themselves up by their bootstraps."
- Depression is as real as other medical conditions such as cancer or diabetes and can and should be treated.

Source: Adapted from World Federation for Mental Health packet on Understanding Generalised Anxiety Disorder.

Types of Depression

Depression is a brain disorder that can take many different forms. Some people will experience one episode of depression in their lifetime; others will have recurrent bouts of depression; and others may be chronically depressed. Some episodes of depression can begin suddenly with no apparent cause while others may be associated with a difficult life situation, such as a death in the family.

Clinically, there are three primary types of depression, with very specific diagnostic criteria. Major depression, also known as unipolar depression; minor depression, often known as dysthymia, a less severe and often chronic depression; and bipolar disorder, also known as manic depression, where periods of depression cycle with periods of mania.

There are additional subcategories of depression. Depending upon where you live, you may hear about these additional types of depression. For example, an educational initiative in **Australia** focuses on three types of depression: melancholic depression, what they define as a primarily biological form of the disease; non-melancholic, defined as primarily situation induced or related to personality style and coping mechanisms; and psychotic depression, which is depression combined with psychotic symptoms, such as delusions and hallucinations.[ii]

This packet will focus on major depression, also called unipolar depression. The information included is also relevant to the subcategories of the illness.

Depression, Worldwide

Who gets depression varies considerably across the populations of the world. Lifetime prevalence rates range from approximately 3 percent in **Japan** to 16.9 percent in the **United States**, with most countries falling somewhere between 8 to 12 percent.[iii] The lack of standard diagnostic screening criteria makes it difficult to compare depression rates cross-nationally. In addition, cultural differences and different risk factors affect the expression of the disorder.[iv]

We do know that the symptoms of depression can be identified in all cultures.[v] Worldwide, there are certain risk factors that make some more likely to get depression than others.

- Gender. Depression is two to three times more common in women, although a few studies, particularly from **Africa** have not shown this. [vi]
- Economic disadvantages, that is, poverty.[vii]
- Social disadvantages, such as low education.[viii]
- Genetics. If you have someone in your immediate family with the disorder, you are two to three times more likely to develop depression at some point in your life.[ix]
- Exposure to violence.[x]
- Being separated or divorced, in most countries, especially for men.[xi]
- Other chronic illness.

Having a combination of these or other risk factors increases your likelihood of developing depression in your lifetime. For example, a recent survey in the United States found that being female; Native American; middle-aged; widowed, separated, or divorced; and low income put you at increased depression risk; while being Asian, Hispanic, or black decreased your risk.[xii]

Having depression is a risk factor for a number of other disorders, including substance abuse, anxiety disorders,[xiii] heart disease, stroke, HIV/AIDS and diabetes. Depression is also a significant risk factor for suicide.

What Causes Depression?

Why someone gets depression is not yet known. Scientists believe there are biological, genetic and emotional factors that combine to influence who will develop the disorder. We do know that depression can run in families. We also know that difficult life experiences, such as the loss of a parent in childhood, the death of a loved one, termination of employment, or a chronic illness can increase someone's chances of getting depression. We also know that certain personal patterns, such as difficulty handling stress, low self-esteem or extreme pessimism, may be contributing factors. In addition, support systems or lack of them, can influence your risk for the disorder.

Summary: What You Know Can Help You

Depression is a serious illness that affects the mind, brain and body. It can affect anyone regardless of age, ethnic background, socio-economic status or gender. The causes of depression are thought to be a combination of genetics, biology and emotional factors.

DIAGNOSING DEPRESSION

Depression is a complex illness, with a complex set of symptoms. There are many checklists and self tests available worldwide to help diagnose depression. These are usually based upon diagnostic criteria for the disorder. Not everyone with depression will experience every symptom. The number and severity of symptoms may vary among individuals and also over time.

Signs and Symptoms

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies or activities that were once enjoyed, including sex
- Decreased energy, fatigue, feeling “slowed down”
- Difficulty concentrating, remembering, making decisions
- Changes in sleep patterns: insomnia, early morning waking or oversleeping
- Appetite and weight changes
- Thoughts of death or suicide, or suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders or chronic pain

If you, or someone you know, is experiencing five or more of these symptoms, over a period of two weeks, or longer, you may have depression. It is important to talk with a healthcare provider.

Episodes of depression may be triggered by difficult life events, such as the loss a loved one or a chronic illness. Or they can just appear for no apparent reason.

Depression Symptoms: Personal, Social and Cultural Issues

Not everyone who has depression will experience every symptom. For some, they feel sad or down, or “blue” and are unable to enjoy their normal activities. They may feel hopeless. They may have trouble sleeping and have no appetite and lose weight. Another person with depression may start eating more and sleeping all the time. They may feel guilty and irritable. Another person may become angry, discouraged or volatile and compulsively throw themselves into their work or hobbies. They may engage in reckless behavior, be suicidal or talk about harming themselves.

Yet all of these people may have depression. People’s experiences with the illness often differ dramatically. Your symptoms can vary based upon who you are as an individual, your gender, your genetics, your coping mechanisms, your support structures, your relationships, and the culture in which you live.

Men, for example, may display different symptoms and behaviours than women. For example, they may present with fatigue, irritability or anger, loss of interest in work or hobbies, recklessness and substance abuse.[xiv]

Across cultures, some people may be more likely than others to experience particular symptoms. For example, some people may experience physical symptoms as a result of their depression. They may have stomach problems or chronic aches and pains, such as a headache that won't go away. These physical symptoms are often a sign of depression. Researchers have shown that depression and pain share biological pathways in the central nervous system that are involved in the transmission, regulation and perception of emotions and pain,[xv] often the same neurotransmitters that depression medications target in treatment.

The Painful Truth, a survey conducted on behalf of the World Federation for Mental Health and the World Organization of Family Doctors, found that people with depression, on average, waited more than 11 months to see a doctor about their symptoms. Even then, they were diagnosed with depression only after five visits to the doctor, further delaying treatment and recovery.

For more details from the survey, go to: http://www.breaking-through-barriers.com/en/survey.pdf

Understanding the common **mind-body connection** in depression is currently a critical area of research. An international survey, the Painful Truth, conducted in **Brazil, Germany, Canada** and **Mexico** on behalf of the World Federation for Mental Health and the World Organization of Family Doctors, revealed substantial gaps in patients' and physicians' knowledge about depression, which lead to misdiagnosis or delayed diagnosis.[xvi] In questioning patients, physicians felt they would be more likely to ask about painful physical symptoms if they had a better understanding of the connection, and would reach a diagnosis of depression more quickly.[xvii]

The survey estimated that nearly 72 percent of people with depression did not believe, prior to their diagnosis, that painful physical symptoms such as unexplained headache, backache, stomach problems, and other vague aches and pains, were common symptoms of depression. However, 79 percent acknowledged that these symptoms to be bothersome enough to prompt them to see a doctor.[xviii]

A recent study in **Brazil** and other **Latin American** cultures found that primary care patients from different cultural backgrounds differed in their explanations and attributions of the physical symptoms associated with depression.[xix] Better understanding these differences, particularly as they relate to the physical

manifestations of the disorder, will help health professionals better identify and treat depression across cultures.

Diagnosis

There are many tools available to diagnose someone with depression. Most of these are based either on the diagnostic criteria provided in the International Classification of Disease (ICD)10 (see box below) or the US-based Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR).

International Classification of Diseases (ICD) 10: Depressive Episode

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

Source: ICD-10, World Health Organization, 2005.

Depression can be reliably diagnosed by a psychiatrist, a psychologist, psychiatric nurse, clinical social worker, primary care practitioner, and a community health worker. An extensive body of research literature has examined the validity of the various diagnostic instruments and screening tools, both as used by trained psychiatrists and psychologists, as well as primary care practitioners. There is increasing evidence that screening can be done across a wide range of settings, by a wide range of professionals, including non-physicians and community health workers.[xx]

Sometimes, mental health organisations or other health agencies will conduct depression screenings in the workplace, in a community setting, or in a local clinic. These screenings generally use similar tools healthcare providers use. In some cases, it has been shown that local adaptation of screening tools by community groups to cultural contexts can be very successful.[xxi] A recent meta-analysis, however, of these screenings done in high-income countries indicated

that systematic screenings may not be the most efficient avenue for detecting depression in individuals. This study found more success in referrals from general practitioners, or primary care practitioners. [xxii]

Where you live and the resources available to you will likely determine how you can get screened for depression. Whether done in a psychiatrist's office or at a depression screening event in a shopping center, the depression screening or diagnostic evaluation will likely include a checklist of symptoms.

You will be asked a series of questions about how you have been feeling. They will ask you questions about your diet, and how you have been eating. They will ask you about your sleep patterns, if you have been feeling tired or having any problems sleeping. They may ask you if you have any aches or pains. The person conducting the screening may also ask you about drug or alcohol use. They may ask you about other members of your family and if they have ever had depression. They will want to know you how long you have been having these feelings, and if anything has changed in your life or your routine. It is also important to tell the person conducting the screening about any medications, nutritional supplements, herbal remedies or homeopathic treatments you may be taking.

One important step, if possible, is to get a physical examination by a health care practitioner to rule out any other possible causes for your symptoms.

Using all of this information, the person conducting the screening will be able to tell you if your symptoms match those of someone with depression. They will provide you with recommendations for treatment or refer you to another health professional. They also may make some recommendations for taking care of yourself.

Internet Screening Tools

There are multiple depression screening tools and self-tests available on the Internet. Many of these tools look the same, a checklist with the various symptoms of depression. There is a growing body of research examining the effectiveness of these various instruments, some of which are proving to be effective. For example, a **Canadian** study tested an Internet-based screener and found it to be reliable for identifying patients with and without major depressive disorder.[xxiii] Another more recent study in **Amsterdam** developed and tested an Internet-based screening tool and found it to be effective in depression, yet also found it produced a high number of false positives.[xxiv]

These Internet self-tests may be helpful to you in trying to determine if what you are feeling is depression. However, they shouldn't be the end of your investigation. Please use caution with the Internet. Be aware of the source and don't consider any treatment suggestions provided without first talking with your healthcare provider.

If you think you may have depression, talk to someone. Often, this is first step to feeling better. That person can be a family member, a friend, a healthcare provider, a minister, a community leader or a traditional healer. Then, try to find someone who can help you get a diagnosis, and ultimately, treatment.

Summary: What You Know Can Help You

Depression is real. There are many signs and symptoms of depression, and each person with the disorder will have a different experience. Getting a diagnosis of depression may be difficult, depending upon where you live, but it is important. Utilise all of the Resources in your community and included in this packet.

TREATING DEPRESSION

There is no cure for depression, but depression can be treated. There are many different types of treatment for depression. The most common treatments are antidepressant medication, psychotherapy, or a combination of the two. Antidepressant medications and brief, structured forms of psychotherapy are effective for 60-80 percent of people with depression.[xxv]

There are other existing treatments for depression, and many types of treatments being studied. Determining the best treatment for you depends on the nature and severity of depression, and often, your individual preference. Working with a healthcare practitioner and/or a psychiatrist is the best way to determine the best treatment for you as an individual.

The following section will summarise some of the current treatments available for depression, and touch on some of the other treatments being researched for the future. The next section will provide information for getting the help you need.

Medications

There are many different kinds of medications used to treat depression. They are often called antidepressants. Some of these medications have been around for decades; some are newer medications, or different formulations of previous medications (such as extended release tablets); and some medicines are currently being researched and tested.

Antidepressants work in different ways, but most act on chemicals in the brain, known as neurotransmitters. How they work is a complicated process. In simple terms, neurotransmitters essentially carry messages from one brain cell to the next. They are the chemicals that are released from one brain cell to be received by the neighboring brain cell. This process is not a one-way street, however. The original brain cell that sent the message also needs to get some of the neurotransmitter back in order to continue healthy function. This process is called re-uptake. Adequate levels of these chemicals, these neurotransmitters, need to be present to (1) send the message to the neighboring brain cell and (2) return to and retore chemical balance to the original brain cell. In disorders such as depression, it is thought that there is not enough of certain neurotransmitters, such as seratonin, dopamine or norepinephrine.

The scientists who discovered this brain process, three men, one from the **United States**, one from the **United Kingdom** and one from **Sweden**, won the Nobel prize for their discoveries.[xxvi] An entire class of medications for depression was built on this neurotransmitter reuptake process. They are the most commonly prescribed medications for depression around the world. Called **selective serotonin-reuptake inhibitors**, or SSRIs, they act only on the neurotransmitter seratonin. They appear to work by blocking (or “inhibiting”) the

reabsorbtion ("reuptake") of the neurotransmitter seratonin. This allows seratonin to remain in the brain longer, and allows for better neurotransmission.

In addtion to SSRI's, there are other classes of medications used to treat depression, which include the following:

- **serotonin and norepinephrine reuptake inhibitors** (SNRIs)
- **tryciclic antidepressants**
- **monomamine oxidase inhibitors** (MAOIs).

You may have heard of some of these medications before, or known someone taking them. They can be prescribed by a healthcare practitioner or a psychiatrist.

If you are considering medication treatment for depression, be aware that once you begin treatment, it may take a few weeks, or up to 6 weeks, to notice improvements in your mood. You should take your medication regularly for full therapeutic effect. In some cases, the dose of the medication may need to be changed, or an alternate medication considered. It can take some time to determine the right medication and the right dose for you.

Some people taking these medications experience side effects that are often temporary. These include dry mouth, bladder problems, constipation, blurred vision, sexual functioning problems, dizziness, drowsiness, increased heart rate, nausea, nervousness or insomnia and agitation. Talking to your healthcare provider is important. Be sure to pay attention to and discuss how the medication is making you feel throughout your body and any changes you are experiencing.

Several years ago, increased suicidal risk was indicated in connection with some antidepressant medications. Many drug makers were required by the US Food and Drug Administration to include a warning on their packaging to monitor for increased suicidal behavior in children, adolescents, and young adults. Since then, studies have indicated that the benefits of these medications in treating depression and anxiety in this population far outweigh the risks.[xxvii] Studies in adults show no increase in suicide risk.[xxviii] Regardless, careful monitoring for suicidal behavior should be part of any treatment plan for depression.

For more information on the medications used to treat depression, the National Institute of Mental Health in the United States maintains a publication that may be helpful, http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml.

Psychotherapy

Psychotherapy, also known as talk therapy or counseling, can take many forms, many of which can be very helpful and therapeutic for someone with depression. Therapy can be done on an individual level, or with a group, or with a spouse or other family members. It can be delivered by a wide range of healthcare professionals: psychiatrists, psychologists, primary care doctors, social workers, psychiatric nurses, therapists, counselors and, in some cases, non-medical personnel.

There are many types of talk therapy across the world, and new therapies being developed and studied. Some of these may be very effective for you. The two types of therapy that have proven to be especially effective in treating depression are:

- Cognitive behavioral therapy (CBT), which works to change negative styles of thinking and behaving that may contribute to depression. It combines cognitive therapy, which helps patients develop healthier thought patterns and behavior therapy, which helps patients respond in new ways to difficult life situations.
- Interpersonal therapy (IPT), which works to change relationships that cause or exacerbate depression. A United States study recently reviewed the outcomes of patients undergoing short term IPT provided by psychiatrists, psychologists, social workers and non mental health workers. Each group showed remission of symptoms, including the non mental health workers.[xxix] Administering treatment by non medical personnel could be economical and expand the reach of effective treatments for people with depression worldwide.

Talk therapy can be hard work. It is important that you go to all of your scheduled appointments on time and keep actively involved in the process.

Internet- or Telephone-Based Psychotherapy Programs

Researchers are looking into various forms of Internet- or telephone-based psychotherapy programs for depression. A recent literature review found evidence of success in studies of telemental health with depression to be encouraging, yet indicated the evidence is still limited.[xxx] Another research study found significant benefits for people receiving cognitive behavioral therapy (CBT) over the phone, reporting more depression-free days than those who did not receive CBT.[xxxi]

These programs could be particularly helpful to people living in rural areas or other places with limited access to other forms of therapy. In addition, they could be a cost-effective way to treat depression.

Some caution should be taken when considering this form of care. This is a relatively new area of treatment, and it is very hard to know the effectiveness or safety of a program on the Internet. Researching any group promoting this kind

of treatment is important before committing to this kind of treatment plan. This would include asking your healthcare provider about the group and/or the treatment plan, consulting a local depression support group (see Resources section) to see if they have any additional information and asking to talk with someone who has participated in this particular treatment. These are all critical steps to take before agreeing to this form of treatment.

Traditional or Alternative Healing Methods

In addition to therapy and medications, traditional or alternative healing methods and self-help techniques are used in many parts of the world to help reduce the symptoms of depression. Many of these methods are currently under study, and include:

- Establishing regular exercise patterns. Exercise can affect the physiological factors that underlie depression, and can increase the levels of certain chemicals in the brain that can make you feel better. Research studies have found regular exercise at a dose consistent with public health recommendations to be an effective treatment for people with mild to moderate depression.[xxxii]
- Increasing exposure to light is a therapy often used for seasonal affective disorder, or what some call winter depression.
- Nutritional supplements. Studies have shown that daily supplements of vital nutrients can reduce symptoms of depression. For example, supplements that contain amino acids are converted to neurotransmitters that alleviate depression and other mental disorders.[xxxiii]
- Relaxation exercises and meditation. Deep relaxation or meditation, a state of concentrated attention on some object of thought or awareness, can also be considered for some of the symptoms of depression, such as difficulty sleeping.
- Acupuncture has been used for depression across many cultures. Research has not proven it be an effective treatment alone. However, one recent study acknowledged that the research setting of the treatment, as compared to traditional settings, may influence these findings.[xxxiv]

Researchers are studying many of these traditional and alternative methods for treating depression. Current studies indicate many may be useful, not alone, but in concert with more conventional treatments.[xxxv] Relying on these methods alone in treating depression is not recommended.

Herbal Remedies

For generations, people have used herbal remedies to help with mood disorders. In the past few decades, researchers have begun to examine some of these historic remedies, particularly one called Hypericum perforatum, or St. John's Wort, a bushy herb with yellow flowers. St John's Wort has been used to treat depression since the 1500s, particularly in places where the herb originates, namely Europe, West Asia, and North Africa.[xxxvi] Currently, in **Germany**, it is the most common treatment.[xxxvii]

The herb works in a similar way to some prescription antidepressants by increasing the brain chemical serotonin, involved in controlling mood. A recent scientific review analysed 29 studies that together included 5,489 men and women with symptoms of major depression. The researchers found that St. John's Wort extracts were not only effective but that fewer people taking them dropped out of the trials due to adverse side effects of the treatment.[xxxviii]

If you are considering or currently taking St. John's Wort for your depression, please be aware that research has found that St. John's Wort can cause other medications not to work, or not to work as effectively.[xxxix] It is always important to talk with your healthcare provider about anything you are taking, including herbal supplements or vitamins, in treating depression or other disorders.

Brain Stimulation Therapies

Brain stimulation therapies are medical procedures that involve activating or touching the brain directly with electricity, magnets or implants to treat depression and other disorders.[xl]

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is one of the most studied neurostimulation therapies for depression, with research spanning seven decades.[xli] It has proven to be an effective treatment for depression. [xlii]

ECT involves producing a seizure in the brain of a patient by applying electrical stimulation to the brain through electrodes placed on the scalp. Repeated treatments are necessary to receive the most therapeutic response and continued relief from symptoms. General anesthesia should be administered.[xliii] Memory loss and other cognitive problems are common, yet typically short lived.

There have been modern advances to the ECT technique, but treatment varies widely from country to country. Controversy surrounds the practice, including the informed consent process for patients. The World Health Organization recommends that ECT should only be used after obtaining informed consent and should only be should only be administered with the use of anesthesia and muscle relaxants.[xliv]

ECT is considered as a treatment based upon the patient's medical history, the severity of depression, as well as any previous treatments and their effectiveness. Sometimes, ECT will be given when a patient cannot take medication for health reasons, or when rapid relief to the symptoms of depression is necessary,[xlv] for example, in patients who are suicidal.[xlvi]

Repetitive Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) involves using a magnet to stimulate the brain. A typical rTMS session lasts less than 60 minutes and does

not require anesthesia. An electromagnetic coil is held against the forehead near an area of the brain that is thought to be involved in mood regulation. [xlvii] Side effects include discomfort in the area where the magnet is placed, jaw or face tightness or tingling during the procedure, headache, and in a few instances, seizure.

Repetitive transcranial magnetic therapy has been shown to relieve symptoms of depression in clinical trials.[xlviii] It is considered as a treatment for patients who have not responded to other treatments. As a relatively unobtrusive treatment, its use is increasing across the world, particularly as an alternative to ECT. [xlix]

Vagus Nerve Stimulation (VNS)

Vagus nerve stimulation (VNS) works through a device implanted under the skin in the upper left side of the chest that sends electrical pulses through the left vagus nerve, up through the neck, and into the brainstem. Research has found that vagus nerves are responsible for carrying messages from the brain to the body's major organs like the heart, lungs and intestines, and to areas of the brain that control mood, sleep, and other functions. Because VNS requires surgery, there are risks associated with any surgical procedure. There are other side effects, such as voice horseness, cough or sore throat, breathing problems, difficulty swallowing, in addition to discomfort or pain in the area of the implant.

In the **United States**, VNS has been approved as a treatment for people with depression lasting longer than two years, if it is severe or recurrent, and if the symptoms of depression have not subsided after trying at least four other treatments.[l]

Deep Brain Stimulation

Deep brain stimulation (DBS) is a form of therapy that has been called a “brain pacemaker,” which utilizies a pair of electrodes that are implanted in the brain and controlled by a generator that is implanted in the chest. The electrodes send electrical pulses to specific parts of the brain at a frequency and level customised to the individual. Originally developed to treat tremors such as those seen in patients with Parkinson’s Disease, the procedure carries multiple risks and is currently only available in research trials for depression.

Treatment Research

There are many existing treatments for depression, and many very effective treatments. There are still patients, however, who do not get better even with treatment; and others who have difficulty with the side effects or risks involved in some of the treatments. Researchers are continuing to seek better and safer treatments for depression.

Improved understanding of the brain, and how it works is leading to new possibilities for treatment, and specifically new areas to target in developing new medications.[li] Scientists are looking at the role that genes play in influencing the

way a patient responds to treatment.[lii] Researchers are also seeking treatments that work more quickly to reduce the symptoms of depression, particularly severe and treatment resistant depression.

Getting Help, Worldwide

There are many possible treatments for depression; and equally, if not more, barriers to getting treatment. Fewer than 25 percent of people across the world have access to treatments for depression.[liii] The World Health Organization recently studied what they call the "treatment gaps" in mental health care and found that worldwide, the median rates for untreated depression is approximately 50 percent.[liv] In some countries, fewer than 10 percent of people with depression receive any treatment.[lv] When people do get treatment, it is often inadequate. A few snapshots from around the world:

The Internet can be a good resource for information on depression. For example, **Multicultural Mental Health Australia** provides information on depression in Arabic, Assyrian, Cambodian/Khmer, Chinese (simple and traditional), Croatian, Dari, English, Farsi, Greek, Indian, Indonesian, Italian, Japanese, Korean, Lao, Macedonian, Polish, Punjabi, Russian, Serbian, Somalian, Spanish, Tamil, Thai, Turkish, and Vietnamese. http://www.mmha.org.au/

- A 2007 international household survey of 84,850 respondents in 17 countries found that unmet needs for mental health treatment are pervasive and especially concerning in less-developed countries.[lvi]
- An international study looking at six locations (**Spain, Israel, Australia, Brazil, Russia** and the **United States**) found it unlikely to receive treatment for depression even after seeing a primary care health practitioner and being diagnosed with depression. This study found the probability of receiving treatment for depression was more influenced by the existing health care systems and financial barriers than by the clinical characteristics of individual patients.[lvii]
- In a recent literature review, researchers reported that only 14 percent of people in **Belgium** seek treatment within a year of onset of depression.[lviii]
- A recent study of several **Latin American** countries found a significant treatment gap for depression in the elderly. This study, in **Peru, Mexico and Venezuela**, found that most participants with symptoms to diagnose them with depression had never received treatment.[lix]
- There are only 26 psychiatrists for approximately 80 million inhabitants of **Ethiopia**, according to a recent survey.[lx] This is the case for many countries around the world: there are limited health professionals available or trained to provide effective treatments.

If you or someone you know is depressed, finding appropriate treatment can be difficult depending upon where you live and the resources available to you. While many treatments can be provided and monitored in primary care,[lxi] barriers to effective care include the lack of resources, lack of trained providers, and the

social stigma associated with mental disorders including depression. Even some of the symptoms of depression can be a barrier to treatment. A person may feel too tired or too overwhelmed to get help.

The first step to finding help is to begin in your community, with resources familiar to you. Try to talk with a healthcare practitioner. If there is no healthcare provider in your community, talk with a representative from a non-governmental organizations (NGOs). An estimated 93 percent of **African** countries and 80 percent of **Southeast Asian** countries have NGOs in the mental health sector.[lxii] These organizations provide diverse services—including counseling, advocacy, informal support, suicide prevention, substance abuse/misuse counseling, and research. In some communities, the NGOs provide the only programs available; in others, they compliment existing programs.

If there is a university nearby, its departments of psychiatry or psychology may be able to help. Or consider a telephone directory or community resource book, and look under "mental health," "social services," "suicide prevention," "crisis intervention," "hotlines," "hospitals," "health clinics," "physicians," or "health." Another source of treatment and support could be a traditional healer, common to many countries and cultures.

Depression may be unfamiliar to people who are trying to help you. Talk to them about the information you have learned in this publication and the resources at the end of this publication.

If you cannot find the help you need, you may need to seek treatment farther away. Utilizing the Internet to find help could be very helpful. If you don't have access, go to a local library or NGO with the resource list at the end of this publication.

Adherence to Treatment: Personal, Social and Cultural Influences

Sticking to your treatment plan for depression can be challenging. Why some patients discontinue their treatments is not well understood.

The nature of depression, and its symptoms, can get in the way of your treatment. You may, for example, feel too tired to go see your therapist. Alternately, you may be struggling with the side effects of the medication you have been prescribed. Or you may feel better and not understand the medication

There are often many barriers to getting treatment for depression. Sometimes, they are related to your personal or community resources. Sometimes, they may be related to stigma or fear that people will judge you. Other times, however, it may be the depression itself that is a barrier. Some of the symptoms you are experiencing may impede your ability to get the treatment you need. For example, you may feel too exhausted or overwhelmed to seek treatment. Or you may feel hopeless and sure that nothing will help.

needs to be continued to keep feeling better.

Research shows that "feeling better" is often the reason patients stop their medication.[lxiii] This indicates a misunderstanding of the way antidepressant medications work. Not surprisingly, a recent study found the physician-patient relationship, including the amount of time the physician takes to explain the treatment and possible side effects, is critical to improving the duration of treatment.[lxiv] Another study, from the **United Kingdom**, found that the lack of available and understandable health information contributes to low levels of treatment compliance.[lxv]

There are social and cultural issues that can impact your treatment, as well. You may be too embarrassed to go to the pharmacist for your medication. You may be worried that people will know you have depression. Or you may not be able to afford to pay for the medication.

If you have additional illnesses co-occurring with depression, this can also complicate your ability to stick with your treatments.

Very often, patients stop treatment without telling their health care providers. A study in **Belgium** found that approximately 25 percent of patients do not inform their physician when they stopped taking their medication.[lxvi]

Summary: What You Know Can Help You

There are many effective treatments for depression. Most people with depression can get better with treatment. However, there are many barriers to accessing treatments around the world. These barriers can be a result of the illness, or your feelings about your illness, as well as social and cultural influences. It may be very challenging, but it is important to try to break down these barriers to get the treatment you need.

LIVING WITH DEPRESSION

Living with depression, especially if it is chronic or recurring, can make you feel exhausted, overwhelmed and helpless. These feelings can often make you want to give up. Recognizing that these negative thoughts are part of your depression is one step toward recovery. It is important to take good care of yourself throughout your treatment. This can be hardest in the beginning, especially before your treatment begins to work.

Taking Care of Yourself

Depression is real. It is an illness of the brain that usually requires some form of treatment. It is important for you to recognise this, to take the illness seriously, and to take good care of yourself.

Depression can make even the simplest parts of daily living very difficult. If possible, there are some things you can do to make yourself feel better, even if only slightly. Your health care practitioner may make some of these suggestions as well.

- Consider some form of exercise daily. Exercise is good for both physical and mental health. It releases chemicals in the brain (seratonin and dopamine) that depressed people lack. Establishing a regular exercise routine will help maintain a healthy weight and reduce stress levels, important for someone with depression.

- Try to eat a healthy balanced diet every day. A healthy diet, which includes whole grains, fresh fruits and vegetables, protein, and is low in fat will help keep your body healthy.

- There are many relaxation techniques to lower your stress, which can help with depression, including mediation and deep breathing. These techniques, widely used around the world, are a low-cost way to lower stress.

- Maintain healthy sleep habits, as much as possible. Set up a regular routine for bedtime and morning to be sure you are getting enough sleep, but not too much sleep.

- Avoid and reduce stress. Stress, both at work and home, can increase your feelings of depression. It is important to avoid stress in your daily life. Keep your working hours predictable and manageable. Openly communicate with family members and loved ones about what is going on in your life to foster better relationships and elicit their support.

- Limit or curtail alcohol or substance use or abuse. Use of these substances may worsen your symptoms of depression or interfere with your prescribed medications.

- Create a daily routine. Organizing and planning your day will help to manage the many daily life tasks that you have to do. Create and maintain a monthly calendar.

- Be patient with yourself. For someone with depression, even the smallest tasks can seem impossible.

If you can't find the energy to go for a walk today, then just stand outside for a little while and get some fresh air. If you can't make a healthy meal for yourself, try to eat a piece of fruit. If you are finding yourself unable to sleep, consider learning meditation or other relaxation techniques. If you are sleeping all of the time, consider ways to spend less time in bed. These things will not make your depression go away, but they may make your day feel a little bit easier.

Seeking Support

A network of family and friends can make all the difference for someone with depression. Seek out friends and family, as well as local organizations, for help in taking care of yourself.

Friends and Family

Family members and close friends can do many things for someone with depression. Family members and close friends can be a significant source of support for you in coping with your depression.

- They can make you feel like you are not alone.
- They can listen to you.
- They can help you to find resources and learn all you can about depression.
- They can help you maintain a healthy lifestyle every day.
- They can help you stick to your treatment plan.

Seek out friends who will stick by you and help you through tough times. Ask them for specific help with daily routines, with getting to therapy, exercising with you and encouraging you to take good care of yourself.

You may need to educate your friends about your depression. They may not understand that depression is an illness and requires treatment. They may expect that you can just pull it together and get better. They may think they can cheer you up. Consider sharing the information in this booklet with them. There is a section for them, on Helping Someone You Know with Depression.

Peer Support Groups

Peer support groups, or group meetings with other people with depression, can be helpful for some people with depression. These groups, especially when well-

run and organised, provide insight into the day-to-day coping with the disorder.

Research has shown these groups to be helpful in particular areas, such as providing support, helping participants cope with problems and crises, and enabling participants to stick to their treatment plans.[lxvii] However, a recent systematic review found that more research is needed to fully understand and evaluate what conditions make these groups effective. Currently most existing peer-to-peer communities have been evaluated only in conjunction with more additional interventions and interactions with healthcare professionals that coincide with participation in these support groups.[lxviii]

To locate a peer support group in your community, consult referral hotlines of professional organizations, including your state, regional or provincial mental health association. Also see Resources section of this publication.

Another consideration is a peer support group on the Internet. Currently, there are multiple organizations running these groups, reaching across the world. There is limited amount of research on the quality of these support groups, and their impact on the symptoms of depression.[lxix]

Nonetheless, depending upon where you live, it may be worthwhile investigating whether an online support group could be helpful for you. As with any online service, please exercise caution when considering it and spend some time researching the organization and the kind of support group they are running. This could include corresponding with the organization and asking them how they determine who can participate in the group and how they monitor the group. Or talk to your healthcare provider or another depression organization (see Resources section) to see if they have heard about this group. Finally, another possibility is to ask to talk with or correspond with someone who has participated in this support group.

Although peer support groups are not for everyone, participation may make you feel less isolated and alone,and provide you with an opportunity to see how others with the disorder are successfully managing their lives. They also offer structured activities to cope with your illness.

Mental Health Organizations

Many local community organizations, together with national organizations, can help by providing information and resources on many issues, from finding mental health service providers to resolving insurance matters to considering issues of employment. See Resources section in the end of this document for local organizations.

Recovery

In many places around the world, mostly developed nations, there has been increasing emphasis on recovery and active illness management for people with

mental disorders, including depression. Borne out of substance abuse and addiction programs, the recovery model emphasizes the following:

- Finding hope;
- Personal empowerment in your own treatment and wellness;
- Expanding knowledge base about your illness and its treatments;
- Establishing support networks and seeking inclusion;
- Developing and refining coping strategies;
- Creating a secure home base;
- Defining a sense of meaning for your life.

Some have pointed to two different models of recovery, one developed by practitioners, the other by patients, or mental health consumers. Both, however, involve to these three points: (1) Each person's path to recovery is unique; (2) recovery is a process, not an end point; and (3) recovery is an active process, in which the individual takes responsibility for the outcome, with success depending primarily on collaboration among helping friends, family, the community and professional supports.[lxx]

Recovery, as a movement, also has its roots in what is seen as a disconnect between health practitioners seeing success in treatment and patients still not feeling well. Many patients with depression report residual depression symptoms despite apparently successful treatment. These same patients felt that successful treatment and recovery should involve psychological well-being.[lxxi] This angle has lead to efforts by some to better link treatment success measures with patient well-being. For example, a group in **Scotland** has developed what they call the Scottish Recovery Indicator, which is a complicated tool to help mental health services ensure that their activities are focused on supporting the recovery of the people who use their services. See http://www.scottishrecoveryindicator.net/.

There are literally hundreds of recovery-based resources across the world. In the **United States,** one such program is the Wellness Recovery Action Plan, which recommends five actions for recovery:

1) Believe in yourself and your recovery.
2) Take personal responsibility.
3) Educate yourself.
4) Stand up for yourself.
5) Learn how to both receive and give support.[lxxii]

Summary: What You Know Can Help You

Living with depression can be difficult. You will need a lot of support to maintain a healthy lifestyle and stick to your treatment. Family members and close friends can play critical roles in your treatment plan. Peer support groups and mental health organizations may also be sources of support for coping with depression. There is a growing emphasis on a recovery model across the world

that involves empowering people with mental illness to take charge of their own illness, their treatment and their lives.

HELPING SOMEONE YOU KNOW WITH DEPRESSION

Friends and family can be a lifeline for someone with depression. You can be a critical factor in their recovery. The information in this section will provide you with some guidelines for providing the best care possible, while taking care of yourself as well.

What You Can Do to Help

Depending on the severity of the depression, there are many things you can do to help. These include, but are not limited to the following:

Talking and Listening

Talking to your loved one about their depression is important. Ask them how they are feeling but don't force them to talk if they aren't interested. Allowing these conversations to be easy and open can show them that you are there to help. It is also good to ask them what is most helpful for them when they are feeling depressed. Listen to what they have to say. Tell them that you are there to listen when they need to talk.[lxxiii]

Understanding Depression

It is also important for you to understand depression, its symptoms, possible course and treatments. This will help you understand your loved one and how he or she is feeling. It will also help you know if your loved one is getting better. The information provided in this packet can help you get a better understanding of the complexity of this disorder. There are also endless Resources online and around the world with additional information.

Supporting Their Treatment

One critical area of support for someone with depression is working with them to maintain their treatment plan, including taking their medications as prescribed, seeing healthcare practitioners as recommended, and seeking additional support as necessary. You may need to be the person to remind your loved one to take their medication every day. You may also help by setting up and/or taking them to their healthcare appointments. If they are not getting better, you may also need to encourage them to seek additional or alternative support. The Treatment section in this packet will provide you with some details about the various treatments available for depression.

Help Navigating the Healthcare System

Healthcare systems can be complex. Depending on where you live and the resources available to you, they can be overwhelming even for someone who doesn't have depression. Helping your loved one find a healthcare practitioner to help them with their depression is invaluable. Helping them pay their medical bills and sort out any insurance issues can also be critical.

Recognizing Warning Signs for Suicide
It is important to know that people with depression are more likely to attempt or commit suicide. Take seriously any comments about suicide or wanting to die. Even if you do not believe they really want to hurt themselves, the person is clearly in distress. See the Suicide portion of this packet for more information.

Help with Day-to-Day Living
Often, people with depression have difficulty with some of the basics of day-to-day living. If severe enough, depression can leave you feeling immobilised, unmotivated and unable to do many of life's simplest tasks. During these times, a person with depression will need support in getting them off the couch, encouraging them to shower, to eat, or to get some fresh air. They will also need help going to the grocery store, cleaning the house and paying bills.

Help in Caring for Children
If the person you know has children, he or she may need support in taking care of them. They may need help getting them to and from school, doing their homework, taking them to activities, reading with them, feeding them and taking care of their basic needs.

Supporting Regular Activities
Try to encourage your loved one maintain the activities they do when they are not depressed. If they play tennis regularly, offer to take them to their matches. If they volunteer at a local clinic, help them get there. If the two of you always went to a weekly movie, still go. You can also support their participation or return to work. Don't force them to do things if they aren't ready, but do try to help them stay involved in their lives.

Taking Care of Yourself

Loving someone with depression can be challenging and exhausting, at times. There are multiple support groups for people who have a friend, family member or other loved one with depression worldwide. There are online resources, often offering support groups for caregivers and friends of people with depression. For example, based out of **Australia**, Reachout.com provides information and tips for loved ones, which include:

- Learning about depression. Having an idea about how someone is affected by depression may help you to understand why they behave in the way that they do. This may help you separate the illness from the person and realise that the person's mood or behavior may not be directed at you personally. Information in this packet is a good resource.
- Putting yourself first occasionally. This can be hard and you may find that you feel guilty when you do something for yourself. This is important however. Making time to do things that you enjoy is an important part of looking after yourself and your family member.

- Taking time out. Having time away from your family member can also be important and allow you to relax. Try to spend some time doing what you enjoy. You may want to play a sport, hang out with friends, listen to music or go for a walk.
- Talking to someone about your feelings. If you are living or caring for someone who is experiencing depression you may sometimes feel you are different or alone. Friends may not understand what it is like for you. Talking to people who are in a similar situation may be helpful. Using the Resources section in this packet is a great place to start to find support for yourself. If you feel like you are having trouble doing day-to-day things it may be helpful to see someone like a psychologist or counselor.[lxxiv]

Summary: What You Know Can Help You

If you know someone with depression, there are many ways, both small and complex, that you can help support them in their recovery. These include listening to their feelings, supporting their treatment, maintaining regular activities and helping them with the simple and complex tasks of life. It is important for you, as a carer and support person, to take good care of yourself as well.

THE EFFECTS OF STIGMA AND DISCRIMINATION ON PEOPLE WITH DEPRESSION

Mental Disorders, including depression, are stigmatised in many countries and cultures, preventing people from seeking treatment.[lxxv] For many people with depression, or symptoms of depression, they may be worried about other people will think if they tell their friends and family that they need help. They may worry that they will be ostracised, personally or professionally. In some places, seeking treatment for depression in not as taboo as it once was, primarily due to increased understanding about depression as a serious disorder of the brain. However, in many cultures worldwide, unfortunately it is still seen as a sign of weakness, rather than strength, to seek help for depression.

Researchers have documented the stigma and discrimination, be it social, employment or housing, against those with mental disorders. Many are examining the impact of stigma on not only the recognition and treatment of depression worldwide, but the experience of symptoms by individuals with depression. A study in **India** found the tendency to perceive and report distress was influenced by social and cultural factors, including the degree of stigma associated with particular symptoms.[lxxvi]

Researchers are working to understand the cultural attitudes towards mental disorders, and to develop programmes to combat this culture-specific stigma. Many of these programs involve increasing awareness about mental illness across communities.

The World Health Organization has recently launched a public health initiative to reduce the impact of depression by closing the "treatment gap" between available cost-effective treatments and the large number of people not receiving it, worldwide.[lxxvii] They are hosting events, disseminating resources, and funding studies across the world.

The World Federation for Mental Health has been promoting the *Breaking Through Barriers* campaign to address the need to provide accurate and up-to-date information about depression in ways that are easily accessible to individuals with symptoms of depression, their family members and their friends. The campaign is working to improve worldwide standards of care in the diagnosis and treatment of depression and reduce the stigma that

Breaking through Barriers, an international public awareness initiative in partnership with the World Federation for Mental Health, was initiated to reduce stigma, and improve the understanding depression worldwide. Information and materials are available in: English, Dutch, Spanish, French, Portuguese, German, Italian, Lithuanian, Russian, Swahili, Mandarin, Hebrew, and Arabic. http://www.breaking-through-barriers.com/

surrounds the disorder and serves as a barrier to effective treatment and recovery.

Countries and communities around the world are developing educational initiatives to raise awareness about depression and reduce the stigma and discrimination often associated with mental illnesses. Many of these programs are available in the Resource section of this packet. One education tool many have employed is using personal narratives, in effect to allow people to see, hear and learn from others who have had depression.

One such example is in **United States**, where the National Institute of Mental Health created the Real Men Real Depression campaign. This program featured the real stories of men who live with depression. The Real Men Real Depression program was adapted in **South Africa**, as a radio education campaign in five languages by the South African Depression and Anxiety Group, and resulted in up to 100 calls to their helpline per day.[lxxviii] Because many cultures around the world have taught men to act tough, to not show their feelings, this campaign utilised real men's stories as a tool to help combat stigma and raise awareness about the illness.

Strategies to Overcome Stigma and Discrimination

There are steps you can take to help combat stigma and discrimination in your community against people with mental illness, including depression:

- Recognise that most mental illnesses are disorders of the brain.
- Be respectful of people with mental illness.
- Don't use disrespectful terms in referring to people with a mental illness, such as retarded, crazy, nuts, or lunatic.
- Refer to a person not just their illness, such as a person who has schizophrenia instead of a schizophrenic.
- Emphasise a person's abilities and strengths rather than their disability or limitations.
- Help dispel myths about mental illness.
- Promote greater awareness of mental illness.
- Encourage people to seek help for mental health problems.[lxxix]

Summary: What You Know Can Help You

People with depression can face stigma and discrimination as a result of their illness. Education and awareness about mental illness and depression as real disorders of the brain can help combat some of the myths and misconceptions across the world.

DEPRESSION AND ITS CO-TRAVELLERS

Depression can coexist with other illnesses, often chronic diseases, such as diabetes (LINK to forthcoming WFMH packet) and heart disease, and can be responsible for a significant proportion of disability associated with these conditions, as well as significantly worse physical health.[lxxx]

Understanding the **mind-body connection** when looking at the co-occurrence of depression with other disorders is an important area of research. We are learning that depression is a much more systemic disorder than previously understood. For example, brain researchers have revealed that depressed patients have a significant loss of cells in the prefrontal cortex, a brain area important in shifting mood from one state to the other, and in restraining the brain's fear response system. The sympathetic nervous systems in these patients see an increase in cortisol and norepinephrine secretions, which creates a highly adverse biochemical environment in the body and is likely to contribute to many different adverse outcomes, including:

- increased abdominal fat, which is strongly linked to heart disease;
- insulin resistance, a precursor to diabetes;
- decreased bone formation and increased bone resorption, which can lead to osteoporosis and bone fractures.[lxxxi]

We know that the risk of depression increases with other neurological disorders, such as Parkinson's disease, stroke, and multiple sclerosis.[lxxxii] We also know that depression is associated with a a 1.5- to 2-fold increased risk of cardiovascular disease, independent of other known risk factors, and is itself linked directly or indirectly to risk factors such as smoking and obesity.[lxxxiii]

In response to the growing body of evidence linking depression and diabetes, a number of global programmes are underway, such as the **Dialogue on Diabetes and Depression**. The World Federation for Mental Health is participating in this initiative, which is (1) taking stock of available knowledge – both scientific evidence and clinical experience – in many countries of the world; and (2) working to define areas of intervention as well as priorities for research concerning the co-morbidity of depression and diabetes. For more information on the Dialogue on Diabetes and Depression, see www.diabetesanddepression.org.

Having diabetes doubles the risk of depression.[lxxxiv] Over the past decade, researchers have gained ground in their efforts to more clearly understand the links between diabetes and depression. A new awareness packet on Diabetes and Depression is available on the WFMH website <www.wfmh.org>. The bi-directional nature of these disorders has been established, that is, depression can lead to diabetes and diabetes can lead to depression.[lxxxv] Untreated depression alongside diabetes can increase the risk for diabetes-related complications, such as heart disease, blindness, amputations, stroke, and kidney disease. By getting

early treatment for depression, people with diabetes can often avoid these serious complications.

However, people with depression are much less likely to follow medical recommendations for treating their depression or other illness, such as diabetes and heart disease. Their physicians also may not recognise underlying depression, nor understand the complications depression can cause, either systemically in the body, or because their patient's depression is influencing their capacity to adhere to their treatment regimen. [lxxxvi]

Recognizing these mind-body connections and how depression may be part of a much more complicated systemic problem continues to be a critical area of research, is leading to new and improved treatments, and will ultimately influence the way the medical profession approaches the disorder.

Research has also shown that depression also co-occurs with other mental illnesses, such as anxiety disorders, which include post-traumatic stress disorder (PTSD), obsessive compulsive disorder, panic disorder, social phobia and generalised anxiety disorders. Some research estimate that approximately 50 percent of those with depression also have anxiety.[lxxxvii] A study in Zurich, Switzerland found that comorbid anxiety and depression tended to be far more persistent than either illness alone.[lxxxviii] The added anxiety disorder can also complicate treatment for each disorder, leading to delayed recovery, increased risk of relapse, greater disability and increased suicide attempts.

Alcohol and substance abuse frequently co-occur with depression. There are mixed reports from researchers whether this use is a symptom of the disorder, or a co-occurring condition. Alcohol and substance abuse can often make it hard to detect an underlying case of depression.

People facing the diagnosis of serious life-threatening illnesses are at risk for depression. These could include diabetes, cancer, or HIV/AIDS. As many as one in three people with HIV/AIDS may suffer from depression.[lxxxix] It is often assumed that depressive feelings are inevitable reactions to being diagnosed with a life threatening illness. It is important to recognise, however, that depression is a separate illness and should be treated.

Suicide

Depression is associated with increased mortality, particularly through suicide.[xc] Research has shown that 90 percent of the people who kill themselves have depression or another diagnosable mental or substance abuse disorder.[xci]

Suicide is a global health concern. According to the World Health Organization (WHO), someone around the globe commits suicide every 40 seconds. For people between the ages of 15 and 44, suicide is the fourth leading cause of

death worldwide.[xcii] Suicides in **Asian** countries account for as much as 60 percent of all suicides in the world.[xciii]

For the elderly in the **United States**, depression is a significant predictor of suicide. It is also a widely under-recognised and undertreated medical illness. In one study, many older adults who committed suicide have visited their primary care physician within one month of the suicide, 20 percent of on the same day.[xciv]

Suicidal risk factors and behavior are complex. Prevention efforts need to match this complexity. There are simple steps, however, that can be taken including raising awareness about mental illnesses, such as depression; expanding the recognition and treatment of these illnesses across the globe; and knowing the warning signs of suicide.

THINKING ABOUT SUICIDE?

If you are thinking about suicide or want to harm yourself, contact your healthcare provider or go to a hospital emergency room immediately.

If someone you know is talking about suicide, do not leave them alone. Take seriously any comments about suicide or wanting to die. Even if you do not believe they really want to hurt themselves, the person is clearly in distress and can benefit from your help in receiving mental health treatment. Contact their healthcare provider or go to a hospital emergency room.

Signs and Symptoms that may accompany suicidal feelings include:

- talking about feeling suicidal or wanting to die, feeling hopeless, that nothing will ever change or get better;
- feeling helpless, that nothing one does makes any difference;
- feeling like a burden to family and friends;
- abusing alcohol or drugs;
- putting affairs in order (e.g., organizing finances or giving away possessions to prepare for one's death);
- writing a suicide note;
- putting oneself in harm's way, or in situations where there is a danger of being killed.[xcv]

Summary: What You Know Can Help You

Depression co-occurs with many other illnesses and diseases, including heart disease, diabetes, cancer, Parkinson's disease, as well as other mental and substance use disorders. If you have another illness in addition to depression, it is important to treat your symptoms of depression, as well as adhering to your

treatment plan for any other co-occuring illness. Depession is a significant risk factor for suicide. Knowing the warning signs for suicide can help to protect you.

REGIONAL PERSPECTIVES ON DEPRESSION: SNAPSHOTS FROM AUSTRALIA, BRAZIL, CANADA, MEXICO

Australia

In Australia, depression will be the second leading cause of disability by the year 2010.[xcvi] In 2001, Australian general practitioners reported depression as the fourth most common illness that they dealt with in their practices.[xcvii]

The Australian Government has developed many national policies and initiatives to address the issue of depression. Australia's diversity--linguistically, culturally, and geographically—requires that these efforts be multi-facetted. A recent review of the policies, research and services in multicultural Australia found limits to what has been done as a result of recent policy changes. It appears that policy implementation lags behind policy intentions. Moreover, innovative efforts in the past have rarely been evaluated for their effectiveness.[xcviii]

Multicultural Mental Health Australia is working to provide national leadership in building greater awareness of mental health and suicide prevention amongst Australians from culturally and linguistically diverse backgrounds. Funded by the Australian government, they have information available in nearly thirty languages and run a national educational campaign for depression, Beyond Blue. The approach of Beyond Blue is to foster sustainable partnerships among organisations, agencies, service providers, community and government sectors, individuals, consumers and caregivers and to promote coordinated

Mick, Age 24
Kimberley, Western Australia

I feel bad a lot, almost all the time. It's like I have a dark cloud over me. Sometimes I feel as if I can't breathe. I also drink too much every day. It doesn't really make me feel any better, but everyone around me drinks a lot. It is just what we do here. A few times the nurse at our clinic has sent me to the dry-out shelter in the next town.

I don't really know what to do about how I feel. I have spent some time on the Internet trying to figure out what is wrong with me, to understand why I feel so bad all the time. I have taken a bunch on online quizzes. They all say that I have depression and should get treatment. But where am I supposed to go? Our clinic only talks to me about my drinking.

I have joined some online groups and blogs. Sometimes it helps to sit down and read about other people who have the same feelings as me. I don't write much about myself. The other day, I found a group offering free therapy online. I am considering signing up but I don't know how to know if the group is legitimate.

Lately, there has been more interest in our people here because there have been so many suicides in our region, by Aborginals mostly. The government has gotten worried. Outsiders are starting to appear to work with the clinic or sometimes, they just seem to wander around our community asking questions about our culture and our feelings. I don't trust them. They don't know anything about us or how we live. But I think next time I see one of them, I will tell them about what I am finding out online and see what they say. They may be my only hope.

activities across Australian communities.[xcix] For more information on Beyond Blue, go to http://www.beyondblue.org.au.

A recent evaluation of Beyond Blue found it to have had an effect on awareness of depression and of discrimination against depressed people across Australia. There was an increase in the percentage of people who said that they or their family or friends had a problem like those seen in the stories shown, and this increase was greater in the states where Beyond Blue had been promoted.[c] Another study of Beyond Blue found greater change in beliefs about depression treatments in those regions where the initiative has been funded, particularly counselling and medication, and about the benefits of help-seeking in general.[ci] These findings were not broken down by ethnicity or race, so the impact of Beyond Blue on particular populations—including indigenous communities--is not known.

A survey of Australian adults, conducted first in 1995 and then again in 2003, found the public showed better recognition of depression and gave more positive ratings for a range of interventions, including help from mental health professionals, medications and psychotherapy. The initial study found the public had attitudes discordant with professionals, whereas eight years later, the findings indicated the public's beliefs were more like those of mental health practitioners. This change could have positive implications for help seeking behaviors in Australia.[cii]

A significant factor for many people with depression in Australia is where you live. There is a robust literature on mental health literacy, worldwide, and its impact on depression treatment and reduction of stigma. However, there has not been adequate research on the mental health literacy of people who live in rural regions of the world. A recent study in Australia examined the impact of remote or rural residence on public knowledge of depression and schizophrenia. The study looked at perceived helpfulness in a range of different health professionals and interventions for depression, as well as causes and prognosis for these disorders. The results indicated that the mental health literacy was similar across remoteness regions studied. The rural groups were more likely to identify unproven treatments, such as alcohol consumption and use of painkillers as helpful in treating depression. The study pointed to a need for mental health awareness campaigns in rural and remote regions, with a focus on communicating effective treatments and how to choose a trained health professional.[ciii]

Another recent Australian study examined depression stigma and did not find remoteness of residence to be a predictor of stigma. However, lower mental health literacy was one of the primary predictors.[civ] The internet has been used worldwide as a tool to educate people about depression and other mental illnesses. A study in Australia found that internet-based applications were effective in reducing stigmatising attitudes about depression and in improving

depression literacy, specifically in rural settings. The study suggested further development and evaluation of programs tailored specifically to rural settings.[cv]

Brazil

In 2009, the Brazilian Medical Association proposed new guidelines for diagnosis and treatment of the most common medical disorders, including depression, based upon a review of existing literature. The purpose of the review was to provide clinicians with tools to make better treatment decisions.[cvi]

In Brazil, as well as other Latin American countries, some of the focus on depression research has been the symptoms. It has become apparent in these cultures, as well as some others, that the experience and expression of depression can be different. For example, a person from Brazil with depression may have headaches that won't go away, stomach problems that don't respond to other treatment, or they may feel angry all the time. They are less likely to report symptoms of sadness, or despair.[cvii] In these cases, depression screening and diagnosis may need to be different, and may need to take place in different settings, such as primary care. Understanding these other experiences of depression will help health professionals in Brazil and around the globe in their identification and treatment.

A recent Brazilian survey revealed a high need for increased information dissemination and education on the range of treatment options for people with depression. This survey of over 1,000 residents of Sao Paulo city indicated that treatments and activities most recommended were psychotherapy

Betina, age 16
Rio de Janeiro, Brazil.

I live in a violent place, my city. In my neighborhood, there is a lot of fighting. There are gangs. People are always getting robbed. Sometimes, it will be a jacket you are wearing; other times, your house. But you never feel safe. When I was 10, I saw a kid get shot 2 blocks from my house. He was the brother of a friend.

When I was 14, I got pregnant. After I had my baby, I starting feeling really sad all the time. I would cry at nothing. I was always tired. I felt overwhelmed trying to take care of my baby. I felt guilty asking for help. Luckily, I had my mom. She loved my baby, and she helped a lot. She also took me to see a spiritist healer.

We are spiritists. There are a lot of us in Brazil. The healer talked to me about the way I was feeling. We prayed together. And then he offered me a passe, which is a kind of blessing and cleansing of my energy. I also attended one séance. Some people may not understand this, but for me, it was good. I felt very loved and supported, which helped me with my feelings. But I still couldn't get rid of this overwhelming sadness.

It was my baby's doctor who finally talked to me about post-partum depression. She called it the mama blues and said sometimes women get sad after they have a baby, that it has to do with all the hormones in our bodies, but for me, it may also have to do with where I grew up. She grew up in Rio de Janeiro too. She knows what life is like here.

She gave me some medicine to take. I felt better pretty quickly. Now I am still taking the medicine, but I don't know how long we will be able to get the medicine. I am also spending more time at our spriritist centre with my baby and my mother. I am thankful for the support around me.

and general activities, such as physical activities and attending church services. Other medical treatments were seen as more harmful than helpful.[cviii]

One area of particular concern is adolescent girls. In Brazil, one out of every four mothers giving birth is an adolescent.[cix] We know that depression is prevalent in women during their childbearing periods. Postpartum depression is moderate to severe depression in a woman after she has given birth. It may occur quite soon after delivery or up to a year later, but most of the time, it occurs within the first 4 weeks. A recent Brazilian study found that younger age, in addition to lower socio-economic status, increases your risk for postpartum depression.[cx] Historically, studies have found that women who have postpartum depression are likely to have experienced prior episodes of depression, though they may not have been diagnosed or treated.[cxi] For adolescent mothers, this may not be the case.

Brazil is also known to be a very violent country. Violence is a major public health concern that has been linked to post-traumatic stress disorder, and other mental illness, including depression. Despite the existing literature, effects of violence on mental health remain under-researched in low and middle-income countries. In particular, it is not known which factors could mediate the association of violence with mental disorders either as risk factors, or protective factors. A new study is underway in two Brazilian large urban areas to further investigate these links between violence and mental health.[cxii]

Canada

About 11 percent of men and 16 percent of women in Canada will experience depression in their lifetime.[cxiii] Recognizing the human and economic toll of this illness, as well as other mental illnesses, on the people of Canada has become a focus of the Canadian government. In 2006, the Canadian federal government released a report, the Human Face of Mental Health and Mental Illness in Canada designed to raise awareness and increase knowledge and understanding about mental health and mental illness in Canada.[cxiv] Also in 2006, the Canadian Senate released a report, ***"Out of the Shadows, At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada."***

One response to these reports has been the establishment of a Mental Health Commission of Canada. In 2007, the Canadian Federal government provided funding to establish and support this commission, charging them with developing a Canadian mental health strategy, expanding information dissemination and exchange about mental illnesses across Canada, and reducing stigma.[cxv] As a result, the Commission has launched Opening Minds, a ten-year anti-stigma, anti-discrimination initiative. The first phase of Opening Minds targets children and youth, and health care providers. The focus is to fund a series of evaluation projects to determine best practices, and then to disseminate these tools and resources on a national scale to other communities and stakeholders wishing to begin their own anti•stigma efforts.

There are multiple privately-sponsored educational efforts underway in Canada, including:

- The Mood Disorders Society of Canada has launched an anti-stigma campaign, called the "elephant in the room" campaign. If you donate money to their organization, they will send you a small blue elephant, with the idea that people place it on their desk at work, or home, or carry it in their car, as a symbol of a "stigma-free" zone.[cxvi] Along with the elephant, they suggest that taking action against depression can be a helpful step in recovery. They have a tip sheet on what you can do about the elephant in the room available at http://www.mooddisorderscanada.ca/documents/Home%20Page/Stigma_ElephantCampaign_EN.pdf.
- To understand the level of awareness of mental illness in Canada, in 2008, the newspaper with the largest national circulation, the Globe and Mail, launched a web-based initiative, Breakdown: Canada's Mental Health Crisis. They collected and produced individual stories, in print, audio and video formats, telling personal experiences with mental illness, stigma, treatment and the mental health system in Canada. Some of these stories, and a letter from the editor of the paper were then sent on to Canadian legislators. For more information on this effort, go to: http://v1.theglobeandmail.com/breakdown/.
- The Blue Wave website was created by a family with a daughter who

committed suicide to act as a resource where youth and parents can learn about the challenges surrounding mental health issues. The purpose is not to provide counseling but to direct people to professionals or organizations who can provide help and assistance. For more information on this effort, go to: http://www.ok2bblue.com/tiki-index.php

- The Canadian Psychiatric Research Foundation, a private charitable organization, raises and distributes funds for mental health and addiction research, and works to translate the knowledge gained from mental health and addiction research.

The Resources section of this packet contains a listing of additional organizations with educational activities and other information for people with depression in Canada.

There is significant depression research underway in Canada. The Canadian Institutes for Health, the Federal agency, founded in 2000 to fund health research, has an Institute for Neurosciences, Mental Health and Addition, which supports research to expand our understanding of mental health and reduce the burden of mental disorders. One of their initiatives is suicide prevention, and they have held a number of workshops to create a national research strategy. Of particular interest has been addressing the number one cause of death of Canadian males between the ages of 20 and 40. In addition, they have partnered with agencies in New Zealand and Australia to look at suicide in Indiginous populations to find ways to foster communication and collaboration, and to form and support workgroups to bring substantive research and prevention efforts forward in a multi-year effort. In Canada, suicide rates in the Aboriginal population are significantly higher than the non-Aboriginal rates. There is some understanding of the causes and factors behind suicidal behavior, but the Institute and its partners are working to develop effective prevention strategies, policies, programs and services.[cxvii]

Mexico

The lifetime prevalence of depression in Mexico is 12.8 percent.[cxviii] In one study, prevalence appeared to coincide with various social vulnerabilities. For example, depression increased with age and decreased with higher education; and among males, the prevalence was higher in rural than urban communities. The same study found that a large percentage of affected individuals have no medical diagnosis.[cxix]

The proportion of the global population aged 60 and over is increasing, more so in Latin America than any other region.[cxx] Depression is one of the most frequent chronic disorders in the elderly worldwide, and is a common source of disability.[cxxi] People often think depression is part of aging, but it is not. Depression prevalence figures among the elderly are scarce in developing countries. A recent study in Mexico, however, found symptoms of depression in one of every eight Mexican older adults.[cxxii] Another study in Mexico, Peru and Venezuala found that most older people with depression had never received treatment.[cxxiii]

Researchers have pointed to a potential surge in depression cases as the population in Mexico ages, increasing public health demands. Some researchers are looking into prevention measures, such as developing programs for "active aging" to empower older adults in a rural Mexican community to take better care of themselves.[cxxiv]

Enrique, 68
Mexico City, Mexico

A few years ago, I started getting these headaches that wouldn't go away, even with aspirin. I went to the local clinic, and they tried a number of different medications for me, most of which made me feel very tired. Then I started to feel angry all of the time. I would snap at my daughter for no reason, mostly because I wanted her to keep her children quiet. I couldn't stand being in the same house with all of that activity. It made me feel anxious and jumpy.

Things got worse. I started staying in my room for most of the day, eating meals there, keeping the curtains closed. My head hurt, my eyes hurt. I was tired all the time. My daughter was very worried about me.

One day when I was at the clinic, there was a new doctor there. She had come from somewhere in Europe. She said something about doing research in Mexico. She asked me a lot of questions about my symptoms. She asked me some strange ones about my feelings. She told me she thought I was suffering from depression. I didn't really understand what she was talking about, but she gave me some new medicine to take. I was willing to try anything. Within three weeks, I felt like my old self again, my headaches were gone. I started playing balero with my grandson again.

I had also been having some problems with my memory. I worried that I had Alzheimer's disease. But the doctor told me that sometimes depression can affect your memory. She was right. Once I started taking the medications they gave me, my brain started to work again. It was a miracle.

I feel lucky. Others are not so lucky, especially in my country.

Another Mexican study was working to develop and implement a model for chronic disease prevention and control in the elderly at the community level. [cxxv]

Many other researchers, however, are looking at the treatment gap, for the elderly and for others with depression. This poses a significant challenge for Mexico and other Latin American countries. These health systems are known for having relatively weak primary care services with a heavy reliance on private specialists. [cxxvi] Yet 9 out of 32 states do not have psychiatrist services.[cxxvii] Accessing treatment, or even diagnosis, for depression in this kind of system is not easy. Even where available, there is extreme under-utilization of mental health services in Mexico.[cxxviii] The Mexican National Comorbidity Study found that fewer than one in five respondents with any psychiatric disorder during the last year used any services. Rates of service use by those with mood disorders were somewhat higher.[cxxix] Yet, another study found a 14 year delay in initial treatment after the first onset of a mood disorder.[cxxx]

DEPRESSION RESOURCE LIST

By country/region

Argentina
Fundacion bipolares de Argentina
Website: www.fubipa.org.ar

Australia
Australian Psychological Society
PO Box 38
Finders Lane
Vic 8009 Australia
Website: www.psychology.org.au

Beyond Blue
PO Box 6100
HawthornWest 3122 Australia
Website: http://www.beyondblue.org.au

Black Dog Institute
Hospital Road
Prince of Wales Hospital
Randwick NSW 2031 Australia
Website: http://www.blackdoginstitute.org.au

Mental Health Foundation of Australia
270 Church Street
Richmond, Vic 3121 Australia
Website: www.mhfa.org.au

Multicultural Mental Health Australia
Locked Bag 7118 Parramatta BC NSW 2150 Australia
Phone: (02) 9840 3333
Fax: (02) 9840 3388
Email: admin@mmha.org.au
Website: http://www.mmha.org.au/

National Mental Health Council of Australia
PO Box 174 Deakin West, ACT 2600, Australia
Phone: (02) 6285 3100
Fax: (02) 6285 2166
Email: admin@mhca.org.au
Website: http://www.mhca.org.au/

FINDING HELP

The World Federation for Mental Health maintains a database of organizations across the world with resources for people with depression and their families. You can search the database specifically for your country by typing its name into the search box and "dep" for depression. Then click on the button that says "all of these words," and SEARCH. Go to http://web.memberclicks.com/mc/directory/viewsimplesearch.do to perform your own customized search for resources in your region.

Reach Out
Website: http://au.reachout.com/find/issues/mental-health-difficulties/mood-disorders

Royal Australian and New Zealand College of Psychiatrists
General Website: http://www.ranzcp.org/
Consumer Inquiries: http://www.ranzcp.org/contacts/consumer-enquiries.html

Austria
Club D&A (Depression and Anxiety Club)
A-1090 Wien, Zimmermanngasse 1A/Hochparterre
Phone: 0676/846 22 816
Fax: 01/40 500 80
Email: office@club-d-a.at
Website: http://www.club-d-a.at/

Belgium
Federation Nationale des Infirmieres de Belgique
36 Avenue de 'Europe Marcinelle 6001 Belgium
Phone: 32 2 537 0193
Website: http://www.fnib.be/

Brazil
The Brazilian Association of Families, Friends and
Sufferers from Affective Disorders (ABRATA)
Av. Paulista, 2644-7 andar - Conj. 71
01310-300 - Sao Paulo - SP, Brazil
Phone: 55 11 256.4831 / 55 11 256.4698
Email: apoio@abrata.org.br
http://www.abrata.org.br

Canada
Blue Wave
Website: http://www.ok2bblue.com/tiki-index.php

Canadian Mental Health Association
Phenix Professional Building
595 Montreal Road, Suite 303
Ottawa, Ontario K1K 4L3 Canada
Website: www.cmha.ca

Canadian Network for Mood and Anxiety Treatments
Website: http://www.canmat.org/

Canadian Psychiatric Association
141 Laurier Avenue West, Suite 701

Ottawa, Ontario K1P 5J3
Phone: (613) 234-2815
Fax: (613) 234-9857
Email: cpa@cpa-apc.org
Website: http://www.cpa-apc.org/index.php

Canadian Psychiatric Research Foundation
33 Richmond St. West, Suite 200
Toronto, ON M5H 2L3
Phone: (416) 351-7757
Website: http://cprf.ca/

Canadian Psychological Association
141 Laurier Avenue West, Suite 702
Ottawa, Ontario K1P 5J3
Phone: (613) 237-2144 Toll free: 1-888-472-0657
Fax: (613) 237-1674
Email: cpa@cpa.ca
Website: http://www.cpa.ca/home/

Clinical Depression in Canada
Website: http://depressionincanada.blogspot.com/2009/11/another-blogger-interested-in.html

Depression Canada
Website: http://www.depressioncanada.com/

Depressive and Manic-Depressive Society of Nova Scotia
Phone: (902) 539-7179

GP Psychotherapy Association (Toronto area)
Phone: (416) 410-6644

Depression Understood
Website: http://www.depression-understood.org/

Health Canada, Mental Health--Depression
Website: http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/depression-eng.php

Healthlink Calgary Health Region (Alberta)
Phone: (403) 943-LINK {(403)-943-5465}
Website: http://www.calgaryhealthregion.ca/healthlink

Mood Disorder Association of Manitoba
4 Fort Street, Suite 100

Winnipeg, Manitoba R3C1C4 CANADA
Phone: (204) 786-0987 Toll-free: 1-800-263-1460
Fax: (204) 786-1904
Email: sdmd@depression.md.ca
Website: www.depression.mb.ca

Mood Disorders Association of British Columbia
Phone: (604) 873-0103
Website: http://www.mdabc.ca/index.php
Email: mdabc@telus.net

Mood Disorders Association of Metropolitan Toronto
Phone: (416) 486-8046
Email: ejonassn@mooddisorders.on.ca

Mood Disorders Association of Ontario (MDAO)
Website: http://www.mooddisorders.on.ca/
Phone: (416) 486-8046 or Toll free 1-888-486-8236

Mood Disorders Society of Canada
Website: http://www.mooddisorderscanada.ca/

National Network for Mental Health
55 King St. Suite 604
St Catharines, ON L2R 3H5
Phone: (905) 682-2423 Toll Free: (888) 406-4663
Fax: (905) 682-7469
Website: http://www.nnmh.ca/

REVIVRE- Association québecoise de soutien aux personnes souffrant de troubles anxieux, dépressifs ou bipolaires
Phone : (514) 529-7552
Website: http://www.revivre.org
Email: revivre@revivre.org

Czech Republic
Terapie.info
Phone: tel: 602 257 571
Email: rektor@terapie.info
Website: http://www.terapie.info/

China
Chinese Mental Health Association
Wah Sum Phone Helpline: 0845 122 8660
Website: http://www.cmha.org.uk/

Denmark
Depressions Foreningen Vendersgade
22 DK–1363 Copenhagen Denmark
Phone: 45 3312 4727
Website: http://depressionsforeningen.dk/

Estonia
Estonian Nurses Union
Koidu 20-34
Tallinn 10316 Estonia
Phone: 372 600 8534
Fax: 372 600 8534
Email: ena@ena.ee

Europe
Global Alliance of Mental Illness Advocacy
Networks (GAMIAN-Europe)
c/p FIAB, rue Washington 60
B-1050 Brussels Belgium
Website: www.gamian.eu

European Federation of Associations of Families of People with Mental Illness (EUFAMI)
Diestsevest 100
B-3000 Leuven Belguim
Website: www.eufami.org

European Depression Association
Website: http://www.eddas.org/

Mental Health Europe (MHE)
Boulevard Clovis 7
B-1000 Brussels BELGIUM
Website: www.mhe-sme.org

Finland
Mieli Maasta ry Depression Awareness
Kauppamiehentie 6 FIN-02100 Espoo
Phone: 358 5 4412112
Email: toimisto@mielimaasta.fi
Website: http://www.mielimastaa.fi

France
Association France Dépression
Email: info@france-depression.org
Website: http://www.france-depression.org

Germany
Bundesverband der Angehörigen psychisch Kranker (BApK)
Website: http://www.bapk.de/

Deutsche Gesellschaft fur Bipolare Storungen e. V.
(DBBS e.V.)
Postfach 920249
21132 Hamburg Germany
Phone: 49 40 85408883
Email: dgbs.ev@t-online.de
Website: www.dgbs.de

Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde
(DGPPN)
Website: http://www.dgppn.de/

Iceland
Gedhjalp
Tryggvagata 9
101 Reykjavik, Iceland
Phone: (354) 552-5990
Fax: (354) 552-5029

Ireland
Aware: Helping to Defeat Depression
72 Lower Leeson Street
Dublin 2 Irelanda
Phone: 01 661 7211
Phone helpline: 1890 303 302
Fax: 01 661 7217
Email: info@aware.ie
Website: http://www.aware.ie/index.htm

Teenline Ireland
Phone helpline: 1800 833 634
Website: http://www.teenline.ie/

Italy
ARETE
Via Maspero, 20 I - 21100
Varese Italy
Phone: 36 335 1026265
Fax: 39 03332 834078
Email: info@depressionearete.it
Website: http://www.depressionearete.it

Japan
Keio University Hospital
35 Shinanocho
Shinjuku-ku, Tokyo 160-8582 Japan
Phone: 03-3353-1121
Website: http://www.hosp.med.keio.ac.jp/

Umegaoka Tokyo Metropolitan Hospital
6-37-10 Matsubara, Setagaya-ku,
Tokyo 156-0043 Japan
Phone: 03-3323-1621 or 03-3323-7621
Website: http://www.byouin.metro.tokyo.jp/umegaoka/index.html

Malta
Malta Mental Health Association
PO Box 19 Mosta Malta
Email: joemagro@maltanet.net

Mexico
Asociación Mexicana para Ayuda Mental en Crisis A.C.
Email: nacho@amamecrisis.com.mx
Website: http://www.amamecrisis.com.mx

Voz Pro Salud Mental
E-mail: vozprosalusmentaldf@yahoo.com.mx
Website: http://www.vozprosaludmental.org.mx

Netherlands
Depressie Centrum
Fonds Psychische Gezondheid
Stationsplein 125
3818 LE AMERSFOORT
Amsterdam Netherlands
Phone: (033) 421 84 10
Fax: (033) 421 84 11
Website: http://www.psychischegezondheid.nl/depressiecentrum

Vereniging voor Manisch Depressieven en Betrokkenen (VMDB)
Kaap Hoorndreef 56-C,
3563 AV Utrecht Netherlands
Website: www.nsmd.nl

New Zealand
Mental Health Foundation of New Zealand
81 New North Road, Eden Terrace, Auckland

Phone: (09) 300 7010
Fax: (09) 300 7020
Website: http://www.mentalhealth.org.nz/page/5-Home
Wellington office phone: (04) 384 4002
Christchurch office phone: (03) 366 6936

New Zealand Depression campaign
Phone helpline: 0800 111 757
Website: http://www.depression.org.nz/

South Africa
South African Depression and Anxiety Group (SADAG)
E-mail: operations@anxiety.org.za
Website: www.anxiety.org.za

South African Federation for Mental Health
Private Bag X 3053
Randburg 2125 South Africa
Phone: 27 (11) 781 1852
Fax: 27 (11) 326 0625
Email: safmh@sn.apc.org
Website: http://www.safmh.org.za/

South African Society of Psychiatrists
Website: http://www.sasop.co.za/

Scotland
Scottish Recovery Network
Baltic Chambers
320-323
50 Wellington Street
Glasgow G2 6HJ
Phone: 0141 240 7790
Fax: 0141 221 7947
Email: info@scottishrecovery.net
Website: http://www.scottishrecovery.net

Spain
Alianza para la Depresion
General Margallo 27 - ID (7th Floor) Spain
Phone: 34 91 570 30 03
Fax: 34 91 570 26 74
Email: smith@alianzadepresion.com
Website: http://alianzadepresion.com/

Switzerland

EQUILIBRIUM - Verein zur Bewältigung von Depressionen
Phone: 0848 143 144
Email: info@depressionen.ch
Website: http://www.depressionen.ch/de/equilibrium/index.php

United States
American Academy of Child & Adolescent Psychiatry
3615 Wisconsin Avenue, N.W.
Washington, DC 20016-3007 USA
Website: www.aacap.org

American Association for Marriage and Family
Therapy (AAMFT)
112 South Alfred Street
Alexandria, VA 22314-3061 USA
Website: www.aamft.org

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901 USA
Website: www.psych.org

Carter Center Mental Health Program
One Copenhill
453 Freedom Parkway
Atlanta, GA 30307
Phone: (404) 420-5100 or (800) 550-3560
E-mail: carterweb@emory.edu
Website: http://www.cartercenter.org/health/mental_health/index.html

Depression & Bipolar Support Association (DBSA)
730 North Franklin Street, Suite 501
Chicago, IL 60610-7224 USA
Website: www.ndmda.org

Helpguide
Website: http://www.helpguide.org/index.htm

SAMHSA Mental Health Information Center
PO Box 42557
Washington DC 20015, USA
Website: www.mentalhealth.samhsa.gov
Mental Health America
2000 North Beauregard Street, Sixth Floor
Alexandria, VA 22311 USA
Website: www.nmha.org

National Alliance on Mental Illness (NAMI)
2107Wilson Boulevard, Suite 300
Arlington, VA 22201-3042 USA
Website: www.nami.org

National Institute of Mental Health (NIMH)
6001 Executive Boulevard
Bethesda, MD 20892 USA
Website: www.nimh.nih.gov

Recovery, Inc.
Website: http://www.recovery-inc.org/

United Kingdom
Clifford Beers Foundation
Website: http://www.cliffordbeersfoundation.co.uk/

Depression Alliance
20 Great Dover Street
London SE1 4LX UK
Email: information@depressionalliance.org
Website: http://www.depressionalliance.org/

Mental Health Foundation
London Office, Ninth Floor
Sea Containers House
20 Upper Ground
London SE1 9QB UK
Website: www.mentalhealth.org.uk

Mind: The Mental Health Charity
PO Box 277 Manchester M60 3XN UK
Phone: 0845 766 0163
Email: info@mind.org.uk
Website: http://www.mind.org.uk/
Local Mind Association: http://www.mind.org.uk/help/mind_in_your_area

Papyrus, Prevention of Young Suicide
Phone helpline: 0870 170 4000
Website: http://www.papyrus-uk.org/

Sane
1st Floor Cityside House
40 Adler Street
London E1 1EE UK

Email: info@sane.org.uk
Phone helpline: 0845 767 8000
Website: http://www.sane.org.uk/

International Groups
Breaking Through Barriers, education website in multiple languages dedicated to depression.
Website: http://www.breaking-through-barriers.com/

Counselor.org
Website: http://www.counselor.org/category/depression

Global Initiative on Psychiatry
PO Box 1282
1200 BG Hilversum NETHERLANDS
Website: www.gip-global.org

International Association of Suicide Prevention
Website: http://www.med.uio.no/iasp/index.html

International Centre on Migration and Health (ICMH)
Website: http://www.icmh.ch/index.htm

International Foundation for Research and Education on Depression
2017-D Renard Court
Annapolis, MD 21401 USA
Website: www.ifred.org

International Society for Affective Disorders
Institute of Psychiatry
PO72 Kings College London,
Denmark Hill
London SE5 84F
UNITED KINGDOM
Office: 020 7848 0295
Fax: 020 7848 0298
Email: caroline.holebrook@iop.kcl.ac.uk
Website: http://www.isad.org.uk

Life Long Mental Health Project
Web site: http://www.lifelongmentalhealth.com/index.html

Menninger Clinic
Website: http://www.menningerclinic.com/

Mental Disability Rights International

1156 15th Street NW
Suite 1001
Washington, DC 20005 USA
Phone: 202.296.0800
Fax: 202.728.3053
Website: http://www.mdri.org/

Suicide and Mental Health Association International
Website: http://suicideandmentalhealthassociationinternational.org/

World Association for Psychosocial Rehabilitation
Website: http://www.wapr.info/index.htm

World Federation for Mental Health
12940 Harbor Drive, Suite 101
Woodbridge, VA 22192 USA
Phone: 703.494.6515
Fax: 703.494. 6518
Email: info@wfmh.com
Website: http://www.wfmh.org/

World Health Organization
Division of Mental Health and Substance Abuse
Geneva CH-1211 SWITZERLAND
Website: www.who.int

World Suicidology Net
Website: http://www.redsuicidiologos.com.ar/

REFERENCES

[i] World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
[ii] Black Dog Institute, http://www.blackdoginstitute.org.au/public/depression/depressionexplained/types.cfm
[iii] Andrade L, Caraveo-Anduaga JJ, et al.The epidemiology of major depressive episodes: results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. Int J Methods Psychiatr Res 2003;12(1):3-21.
[iv] Weissman MM, Bland RC, et al. Cross-national epidemiology of major depression and bipolar disorder. JAMA 1996;276(4):293-9.
[v] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[vi] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[vii] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[viii] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[ix] Klerman GL, Weissman MM. Increasing rates of depression. JAMA 1989;261(15): 2229-35.
[x] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[xi] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009; 6(10): 1-7.
[xii] Hasin DS, Goodwin RD, et al. Epidemiology of major depressive disorder: results from the National Epidemiologic Survey on Alcoholism and Related Conditions. Arch Gen Psychiatry 2005 Oct;62(10):1097-106.
[xiii] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[xiv] Wilhelm KA. Men and depression. Aust Fam Physician 2009 Mar;38(3):102-5.
[xv] Bair MJ, et al. Depression and Pain Comorbidity. A Literature Review. Arch Internal Med 2003; 163(20).
[xvi] Bradvik L, Berglund M. Late mortality in severe depression. Acad Psychiatry Scand. 2001;103:111-116.
[xvii] The Mind Body Connection Survey conducted by Harris Interactive, 2007. Summary results available in PR Newswire story at http://www.prnewswire.co.uk/cgi/news/release?id=210366.
[xviii] The Mind Body Connection Survey conducted by Harris Interactive, 2007. Summary results in PR Newswire story, International Survey Shows People With Depression Unaware of Painful Physical Symptoms of Depression, Delaying Treatment and Compromising Recovery, http://www.prnewswire.co.uk/cgi/news/release?id=146908.
[xix] Jorge MR. Depression in Brazil and other Latin American countries. Seishin Shinkeigaku Zasshi 2003;105(1):9-16.
[xx] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.
[xxi] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.

[xxii] Cuijpers P, van Straten A, et al. Psychological treatment of depression in primary care: a meta-analysis. Br J Gen Pract 2009;59:e51-60.
[xxiii] Farvolden P, McBride C, et al. A Web-based screening instrument for depression and anxiety disorders in primary care. J Med Internet Res 2003 Jul-Sep;5(3):e23. Epub 2003 Sep 29.
[xxiv] Donker T, van Straten A, et al. A brief Web-based screening questionnaire for common mental disorders: development and validation. J Med Internet Res 2009 Jul 24;11(3):e19.
[xxv] World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
[xxvi] Retrieved from http://nobelprize.org/nobel_prizes/medicine/laureates/1970/press.html.
[xxvii] National Institute of Mental Health, http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/antidepressant-medications-for-children-and-adolescents-information-for-parents-and-caregivers.shtml
[xxviii] Khan A, Khan S, et al. Suicide rates in clinical trials of SSRIs, other antidepressants, and placebo: Analysis of FDA Reports. Am J Psychiatry 160:790-792, April 2003. Retrieved from http://ajp.psychiatryonline.org/cgi/content/full/160/4/790.
[xxix] Weissman MM. Recent non-medication trials of interpersonal psychotherapy for dpression. Int J Neuropsychopharmacol 2007;10(1):117-22.
[xxx] Hailey D, Roine R, Ohinmaa A. The effectiveness of telemental health applications: a review. Can J Psychiatry 2008 Nov;53(11):769-78.
[xxxi] Simon GE, Ludman EJ, et al. Incremental benefit and cost of telephone care management and telephone psychotherapy for depression in primary care. Arch Gen Psychiatry 2009; 66(10):1081-89.
[xxxii] Dunn AL, Trivedi MH, et al. Exercise treatment for depression: efficacy and dose response. Am J Prev Med 2005 Jan;28(1):1-8.
[xxxiii] Lakhan SE, Vieira KF. Nutritional therapies for mental disorders. Nutr J. 2008 Jan 21;7:2.
[xxxiv] Allen JJ, Schnyer RN, et al. Acupuncture for depression: a randomized controlled trial. J Clin Psychiatry. 2006 Nov;67(11):1665-73.
[xxxv] Manber R, Allen JJ, Morris ME. Alternative treatments for depression: empirical support and relevance to women. J Clin Psychiatry 2002 Jul;63(7):628-40.
[xxxvi] Saller R, Melzer J, Reichling J. St. John's Wort (Hypericum perforatum): a plurivalent raw material for traditional and modern therapies (article in German). Forsch Komplementarmed Klass Naturheilkd 2003 Apr;10 Suppl 1:33-40.
[xxxvii] Baruch Y. Hypericum extract for treatment of depression: what's new? (in Hebrew). Harafuah 2009 Mar;148(3):183-5, 210, 209.
[xxxviii] Linde K, Berner MM, Kriston L. St John's wort for major depression. Cochrane Database Syst Rev 2008; Issue 4.
[xxxix] US Food and Drug Administration, Risk of Drug Interactions with St. John's Wort and Indinavir and other Drugs, 10 Feb 2000. Available from http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm052238.htm
[xl] National Institute of Mental Health, retrieved from http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml
[xli] Kennedy SH, Miley R, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. IV. Neurostimulation therapies. J Affect Disord 2009 Oct;117 Suppl 1:S44-53.

[xlii] Rudorfer MV, Henry ME, Sackeim HA (2003). "Electroconvulsive therapy". In A Tasman, J Kay, JA Lieberman (eds) Psychiatry, Second Edition. Chichester: John Wiley & Sons Ltd, 1865–1901.
[xliii] WHO Resource Book on Mental Health, Human Rights, and Legislation. http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf
[xliv] WHO Resource Book on Mental Health, Human Rights, and Legislation. http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf
[xlv] Kellner CH, Tobias KG, et al. Electroconvulsive therapy for an urgent social indication. ECT. 2009 Dec;25(4):274-5
[xlvi] U.S. Surgeon General (1999). *Mental Health: A Report of the Surgeon General*, chapter 4.
[xlvii] National Institute of Mental Health, retrieved from http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml
[xlviii] Brunelin J, Poulin E, et al. Efficacy of repetitive transcranial magnetic stimulation (rTMS) in major depression: a review, artcle in French. Encephale 2007 Mar-Apr;33(2):126-34.
[xlix] National Institute of Mental Health, retrieved from http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml
[l] National Institute of Mental Health, retrieved from http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml
[li] Holtzheimer PE, Nemeroff CB. Novel targets for antidepressant therapies. Curr Psychiatry Rep 2008 Dec;10(6):465-73.
[lii] Perlis RH, Moorjani P, et al. Pharmacogenetic analysis of genes implicated in rodent models of antidepressant response: association of TREK1 and treatment resistance in the STAR*D study. Neuropsychopharmacology 2008;33:2810-19. Available online at http://www.nature.com/npp/journal/v33/n12/abs/npp20086a.html
[liii] World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
[liv] Kohn R, Saxena S, et al. The treatment gap in mental health care. Bull World Health Organ 2004 Nov;82(11):858-66. Epub 2004 Dec 14.
[lv] World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
[lvi] Wang PS, Aguilar-Gaxiola S, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Lancet 2007 Sep 8;370(9590):841-50.
[lvii] Simon GE, Fleck M, et al.Prevalence and predictors of depression treatment in an international primary care study. Am J Psychiatry. 2004 Sep;161(9):1626-34.
[lviii] Bruffaerts R, Bonnewyn A, Demyttenaere K. The epidemiology of depression in Belgium. A review and some reflections for the future [Article in Dutch]. Tijdschr Psychiatr 2008;50(10):655-65.
[lix] Guerra M, Ferri CP, et al. Late-life depression in Peru, Mexico and Venezuela: the 10/66 population-based study. Bri J Psychiatry (2009) 195: 510-515.
[lx] , Shibre T, Spångéus A, et al. Traditional treatment of mental disorders in rural Ethiopia. Ethiop Med J 2008 Jan;46(1):87-91.
[lxi] World Health Organization, http://www.who.int/mental_health/management/depression/definition/en/
[lxii] Hyman S, Chisholm D, et al. Mental Disorders. 2006. Disease Control Priorities in

Developing Countries (2nd Edition), New York: Oxford University Press, 2006: 5/Chpt-31.
[lxiii] Demyttenaere K, Enzlin P. Compliance with anti-depressants in a primary care setting, 1; Beyond lack of efficacy and adverse events. J Clin Psychiatry 2001;62(suppl 22):30-3.
[lxiv] Demyttenaere K. Risk Factors and predictors of compliance in depression. Eur Neuropsychopharmacol 2003;13(suppl 3):s69-75.
[lxv] Elgie R. A patient and primary care perspective: a patient's perspective on the treatment of depression. J Clin Psychiatry 2006;67(suppl 6):38-40.
[lxvi] Demyttenaere K. Risk Factors and predictors of compliance in depression. Eur Neuropsychopharmacol 2003;13(suppl 3):s69-75.
[lxvii] Depression and Bipolar Alliance Support Groups: An important step on the road to recovery, 2008. Downloaded on 18 Dec 2009 from http://www.dbsalliance.org/site/DocServer/DBSASupportGrps_0708_FINAL.pdf?docID=2381.
[lxviii] Eysenbach G, Powell J, et al. Health related virtual communities and electronic support groups: systematic review of the effects of online peer to peer interactions. BMJ 2004 May 15;328(7449):1166.
[lxix] Griffiths KM, Calear AL, et al. Systematic Review on Internet Support Groups (ISGs) and Depression (1): Do ISGs Reduce Depressive Symptoms? J Med Internet Res 2009;11(3):e40. Available online, http://www.jmir.org/2009/3/e40/
[lxx] Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. A report of the Standing Senate Committee on Social Affairs, Science and Technology, May 2006. Retrieved from http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/rep02may06-e.htm
[lxxi] Fava GA, Ruini C, Belaise C. The concept of recovery in major depression. Psychol Med 2007 Mar;37(3):307-17.
[lxxii] Retrieved from www.mentalhealthrecovery.com.
[lxxiii] Reachout.com, http://au.reachout.com/find/articles/living-with-someone-experiencing-depression.
[lxxiv] Extrapolated from Reachout.com, http://au.reachout.com/find/articles/living-with-someone-experiencing-depression.
[lxxv] Weiss MG, Jadhav S, et al. Psychiatric stigma across cultures: Local validation in Bangalore and London. Anthrop Med 2001; 8(1): 71-87.
[lxxvi] Raguram R, Weiss MG, et al. Stigma, depression, and somatization in South India. Am J Psychiatry 1996;153(8):1043-9.
[lxxvii] World Health Organization, http://www.who.int/mental_health/management/depression/depressioninph/en/
[lxxviii] South African Depression and Anxiety Group (Sadag), via web search, conducted Dec 1, 2009. http://www.sadag.co.za/index.php/Depression/Real-Men.-Real-Depression.html. News report on campaign, http://www.iol.co.za/index.php?sf=13&set_id=1&click_id=13&art_id=qw1059741002611B243
[lxxix] Excerpt from Understanding Generalised Anxiety Disorder, an international mental health awareness from the World Federation for Mental Health. http://www.wfmh.org/PDF/GAD%20Body-Toc%20cx.pdf
[lxxx] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009;6(10):1-7.

[lxxxi] Gold PW, Charney DS. Depression: Disease of the mind, brain and body. Am J Psychiatry 2002;159:1826.
[lxxxii] Rickards H. Depression in neurological disorders: Parkinson's disease, multiple sclerosis, and stroke. J Neurol Neurosurg Psychiatry 2005; 76: i48–i52.
[lxxxiii] Schulman J and Shapiro BA. Depression and dardiovascular disease: What is the correlation?". Psychiatric Times 2008;25(9).
[lxxxiv] Anderson RJ, Lustman PJ, et al. Prevalence of depression in adults with diabetes: A systematic review. Diabetes 2000;49(suppl 1):A64.

[lxxxv] Lustman PJ, Penckofer SM, Clouse RE. Recent advances in understanding depression in adults with diabetes. Curr Diab Rep 2007;7:114-122.

[lxxxvi] Schulman J and Shapiro BA. Depression and dardiovascular disease: What is the correlation?". Psychiatric Times 2008;25(9).
[lxxxvii] ^ Kessler RC, Nelson C, McGonagle KA. Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey. Brit J Psychiatr 1996;168(suppl 30):17–30
[lxxxviii] Merikangas KR, Zhang H, et al. Longitudinal trajectoriesof depression and anxiety in a prospective community study: the Zurich Cohort Study. Arch Gen Psychiatry 2003; 60(10):993-1000.
[lxxxix] Bing EG, Burnam MA, et al. Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. Arch Gen Psychiatry 2001 Aug;58(8):721-8.
[xc] Vikram P, Simon G, et al. Packages of care for depression in low- and middle-income countries. PLOS Med 2009; 6(10): 1-7.
[xci] Moscicki EK. Epidemiology of completed and attempted suicide: toward a framework for prevention. Clinical Neuroscience Research 2001;1:310-23.
[xcii] World Health Organization. World Report on Violence and Health, Geneva. October 2002. Available from www.who.int
[xciii] Wei KC, Chua HC. Suicide in Asia. Int Rev Psychiatry. 2008 Oct;20(5):434-40.
[xciv] Conwell Y. Suicide in later life: a review and recommendations for prevention. Suicide Life Threatening Behavior 2001;31(Suppl):32-47.
[xcv] Excerpted from Learning About Bipolar Disorder, an educational packet of information from the World Federation for Mental Health, 2008.
[xcvi] Mathers CD, Vos ET, Stevenson CE, Begg J: The Australian burden of disease study: measuring the loss of health from diseases, injuries and risk factors. Medical Journal of Australia 2000;172:592-596.
[xcvii] Depression. Australian Channel 10 website, http://9am.ten.com.au/health-and-fitness-depression.htm.
[xcviii] Minas H, Klimidis S, Kokanovic R. Depression in multicultural Australia: Policies, research and services. Austral New Zea Health Pol 2007;4(16). Available at http://www.anzhealthpolicy.com/content/4/1/16.
[xcix] Minas H, Klimidis S, Kokanovic R. Depression in multicultural Australia: Policies, research and services. Austral New Zea Health Pol 2007;4 (16). Available at http://www.anzhealthpolicy.com/content/4/1/16.
[c] Jorm AF, Christensen H, Griffiths KM.Changes in depression awareness and attitudes in Australia: the impact of beyondblue: the national depression initiative. Aust N Z J Psychiatry 2006 Jan;40(1):42-6.

[ci] Jorm AF, Christensen H, Griffiths KM. The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. Aust N Z J Psychiatry 2005 Apr;39(4):248-54.
[cii] Jorm AF, Christensen H. The public's ability to recognize mental disorders and their beliefs about treatment: changes in Australia over 8 years. Aust N Z J Psychiatry 2006 Jan; 40(1):36-41.
[ciii] Griffiths KM, Christensen H, Jorm AF. Mental Health Literacy as a function of residence. BMC Public Health 2009;9:92.
[civ] Griffiths KM, Christensen H, Jorm AF. Predictors of depression stigma. BMC Psychiatry 2008;8:25.
[cv] Griffiths KM, Christensen H. Internet-based mental health programs: a powerful tool in the rural medical kit. Aust J Rural Health 2007 Apr;15(2):81-7.
[cvi] Fleck MP, Berlim MT, et al. Review of the guidelines of the Brazilian Medical Association for the treatment of depression (in Portuguese). Rev Bras Psiquiatr 2009 May;31 Suppl 1:S7-17.
[cvii] Jorge MR. Depression in Brazil and other Latin American countries. Seishin Shinkeigaku Zasshi 2003;105(1):9-16.
[cviii] Blay SL. Public beliefs about the treatment of schizophrenia and depression in Brazil. Int J Social Psychiatry 2009;55(1):16-27.
[cix]Cantilino A, Barbosa EM, Petribu K. Postpartum depression in adolescents in Brazil: an issue of concern. Arch Women Mental Health 2007;10(6):307-8.
[cx]Cantilino A, Barbosa EM, Petribu K. Postpartum depression in adolescents in Brazil: an issue of concern. Arch Women Mental Health 2007;10(6):307-8.
[cxi] Marcus SM. Depression during pregnancy: rates, risks and consequences--Motherisk Update 2008. Can J Clin Pharmacol. 2009 Winter;16(1):e15-22. Epub 2009 Jan 22.
[cxii] Andreoli SB, Ribeiro WS, et al. Violence and post-traumatic stress disorder in Sao Paulo and Rio de Janeiro, Brazil: the protocol for an epidemiological and genetic survey. BMC Psychiatry 2009 Jun 7;9:34.
[cxiii]Retrieved from Health Canada, the Canadian Federal government health agency, http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/depression-eng.php
[cxiv] The Human Face of Mental Health and Mental Illness in Canada. Retrieved from the Public Health Agency of Canada website, http://www.phac-aspc.gc.ca/publicat/human-humain06/.
[cxv]Retrieved from Health Canada, the Canadian Federal government health agency, http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/depression-eng.php
[cxvi] Retrieved from Mood Disorders Association of Canada, http://www.mooddisorderscanada.ca/.
[cxvii] Retrieved from Canadian Institute for Heath Research website, http://www.cihr-irsc.gc.ca/e/32133.html.
[cxviii] Slone LB, Norris FH, et al. Epidemiology of major depression in four cities in Mexico. Depression Anxiety 2006;23(3):158-67.
[cxix]Belló M, Puentes-Rosas E, et al. Prevalence of depression in Mexico (article in Spanish). Salud Publica Mex. 2005;47 Suppl 1:S4-11
[cxx] Guerra M, Ferri CP, et al. Late-life depression in Peru, Mexico and Venezuela: the 10/66 population-based study. Br J Psychiatry 2009 Dec;195(6):510-5.
[cxxi] Mendoza-Núñez VM, Martínez-Maldonado Mde L, Correa-Muñoz E. Implementation of an active aging model in Mexico for prevention and control of chronic diseases in the elderly. BMC Geriatr 2009 Aug 26;9:40.
[cxxii] García-Peña C, Wagner FA, et al. Depressive symptoms among older adults in Mexico City. J Gen Intern Med 2008 Dec;23(12):1973-80. Epub 2008 Sep 26.

[cxxiii] Guerra M, Ferri CP, et al. Late-life depression in Peru, Mexico and Venezuela: the 10/66 population-based study. Br J Psychiatry 2009 Dec;195(6):510-5.
[cxxiv] de la Luz Martínez-Maldonado M, et al. Program of active aging in a rural Mexican community: a qualitative approach. BMC Public Health 2007 Oct 3;7:276
[cxxv] Mendoza-Núñez VM, Martínez-Maldonado Mde L, Correa-Muñoz E. Implementation of an active aging model in Mexico for prevention and control of chronic diseases in the elderly. BMC Geriatr 2009 Aug 26;9:40.
[cxxvi] Guerra M, Ferri CP, et al. Late-life depression in Peru, Mexico and Venezuela: the 10/66 population-based study. Br J Psychiatry 2009 Dec;195(6):510-5.
[cxxvii] Powerpoint presentation from director of Mexican NGO, Voz Pro Salud Mental, retrieved from http://74.125.93.132/search?q=cache:iT4-k7v-cmQJ:www.wfmh.org/TRANSC/Gabriela%2520Camara%2520Caregivers%2520Burden.ppt+mexico+AND+government+AND+mental+health&cd=4&hl=en&ct=clnk&gl=us&client=safari.
[cxxviii] Medina-Mora ME, Borges G, et al. Prevalence, service use, and demographic correlates of 12-month DSM-IV psychiatric disorders in Mexico: results from the Mexican National Comorbidity Survey. Psychol Med 2005 Dec;35(12):1773-83.
[cxxix] Borges G, Medina-Mora ME, et al.
Treatment and adequacy of treatment of mental disorders among respondents to the Mexico National Comorbidity Survey. Am J Psychiatry 2006 Aug;163(8):1371-8.
[cxxx] Borges G, Wang PS, et al. Delay of first treatment of mental and substance use disorders in Mexico. Am J Public Health 2007 Sep;97(9):1638-43. Epub 2007 Jul 31.

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This international mental health awareness packet was supported by an unrestricted educational grant from WYETH Pharmaceuticals which had no control over its content