Center for Disease Control- National Depression Screening Day

New data show nearly 1 in 10 US adults report current depression.

Depression can adversely affect the course and outcome of common chronic conditions, such as arthritis, asthma, cardiovascular disease, cancer, diabetes, and obesity. Depression also can result in increased work absenteeism, short-term disability, and decreased productivity.

In recognition of National Depression Screening Day on October 7, 2010, CDC is highlighting adult depression data.

Current Depression in U.S. Adults

To estimate the prevalence of current depression, CDC analyzed Behavioral Risk Factor Surveillance System (BRFSS) survey data from 2006 and 2008. Current depression was defined as meeting criteria for either major depression or "other depression" during the 2 weeks preceding the survey. The MMWR report on current depression among U.S. adults summarizes the results of that analysis, which indicated that, among 235,067 adults (in 45 states, the District of Columba [DC], Puerto Rico, and the U.S. Virgin Islands), 9% met the criteria for current depression, including 3.4% who met the criteria for major depression. In this study, increased prevalence of depression was found in southeastern states, where a greater prevalence of chronic conditions associated with depression has been observed (e.g., obesity and stroke). By state, age-standardized estimates for current depression ranged from 4.8% in North Dakota to 14.8% in Mississippi. The map below displays prevalence of current depression among US adults by state and territory for 2006 and 2008 BRFSS data.

Who Tends to be Most Depressed?

This study found that persons 45-64 years of age, women, blacks, Hispanics, and non-Hispanic persons of other races or multiple races, those with less than a high school education, previously married, unable to work or unemployed, and without health insurance coverage were more likely to meet criteria for major depression. Other depression (or minor depression) results were similar except that 19-24 year olds reported it more than other age groups.

Treatment of Depression

The U.S. Preventive Services Task Force recommends that health-care providers screen adults for depression when programs are in place to ensure that accurate diagnosis and effective treatment can be provided with careful monitoring and follow-up. The Task Force on Community Preventive Services recommends collaborative care, an approach that involves the collaboration of primary care providers, mental health specialists and other providers to improve disease management for adults with major depression on the basis of strong evidence of effectiveness in improving short-term depression outcomes.

Data Source: CDC. Current Depression Among Adults --- United States, 2006 and 2008. MMWR 2010;59(38);1229-1235.

Depression – World Health Organization

What is depression?

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 lives every year.

Depression is the leading cause of disability as measured by YLDs and the 4th leading contributor to the global burden of disease (DALYs) in 2000. By the year 2017, depression is projected to reach 2nd place of the ranking of DALYs calcuated for all ages, both sexes. Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined.

Depression occurs in persons of all genders, ages, and backgrounds.

Facts

- Depression is common, affecting about 121 million people worldwide.
- Depression is among the leading causes of disability worldwide.
- Depression can be reliably diagnosed and treated in primary care.
- Fewer than 25 % of those affected have access to effective treatments.

Depression can be reliably diagnosed in primary care. Antidepressant medications and brief, structured forms of psychotherapy are effective for 60-80 % of those affected and can be delivered in primary care. However, fewer than 25 % of those affected (in some countries fewer than 10 %) receive such treatments. Barriers to effective care include the lack of resources, lack of trained providers, and the social stigma associated with mental disorders including depression.

Primary care based quality improvement programs for depression have been shown to improve the

- quality of care,
- satisfaction with care
- health outcomes,
- functioning,
- economic productivity,
- and household wealth at a reasonable cost

National Institute of Health

The Numbers Count: Mental Disorders in America

Describes statistics about mental disorders.

- Mental Disorders in America
- Mood Disorders
    - Major Depressive Disorder
    - Dysthymic Disorder
    - Bipolar Disorder
    - Suicide
- Schizophrenia
- Anxiety Disorders
    - Panic Disorder
    - Obsessive-Compulsive Disorder (OCD)
    - Post-Traumatic Stress Disorder (PTSD)
    - Generalized Anxiety Disorder (GAD)

Mental Disorders in America

Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.[1] When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people.[2] Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 — who suffer from a serious mental illness.[1] In addition, mental disorders are the leading cause of disability in the U.S. and Canada.[3] Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity.[1]

In the U.S., mental disorders are diagnosed based on the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).[4]

Mood Disorders

Mood disorders include major depressive disorder, dysthymic disorder, and bipolar disorder.

- Approximately 20.9 million American adults, or about 9.5 percent of the U.S.

population age 18 and older in a given year, have a mood disorder.[1,2]

- The median age of onset for mood disorders is 30 years.[5]
- Depressive disorders often co-occur with anxiety disorders and substance abuse.[5]

Major Depressive Disorder

- Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15-44.[3]
- Major depressive disorder affects approximately 14.8 million American adults, or about 6.7 percent of the U.S. population age 18 and older in a given year.[1, 2]
- While major depressive disorder can develop at any age, the median age at onset is 32.[5]
- Major depressive disorder is more prevalent in women than in men.[6]

Dysthymic Disorder

- Symptoms of dysthymic disorder (chronic, mild depression) must persist for at least two years in adults (one year in children) to meet criteria for the diagnosis. Dysthymic disorder affects approximately 1.5 percent of the U.S. population age 18 and older in a given year.[1,] This figure translates to about 3.3 million American adults.[2]
- The median age of onset of dysthymic disorder is 31.[1]

Bipolar Disorder

- Bipolar disorder affects approximately 5.7 million American adults, or about 2.6 percent of the U.S. population age 18 and older in a given year.[1, 2]
- The median age of onset for bipolar disorders is 25 years.[5]

Suicide

- In 2006, 33,300 (approximately 11 per 100,000) people died by suicide in the U.S.[7]
- More than 90 percent of people who kill themselves have a diagnosable mental disorder, most commonly a depressive disorder or a substance abuse disorder.[8]
- The highest suicide rates in the U.S. are found in white men over age 85.[9]

- Four times as many men as women die by suicide[9]; however, women attempt suicide two to three times as often as men.[10]

Schizophrenia

- Approximately 2.4 million American adults, or about 1.1 percent of the population age 18 and older in a given year,[11, 2] have schizophrenia.
- Schizophrenia affects men and women with equal frequency.[12]
- Schizophrenia often first appears in men in their late teens or early twenties. In contrast, women are generally affected in their twenties or early thirties.[12]

Anxiety Disorders

Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder, and phobias (social phobia, agoraphobia, and specific phobia).

- Approximately 40 million American adults ages 18 and older, or about 18.1 percent of people in this age group in a given year, have an anxiety disorder.[1,2]
- Anxiety disorders frequently co-occur with depressive disorders or substance abuse.[1]
- Most people with one anxiety disorder also have another anxiety disorder. Nearly three-quarters of those with an anxiety disorder will have their first episode by age 21.5 [5]

Panic Disorder

- Approximately 6 million American adults ages 18 and older, or about 2.7 percent of people in this age group in a given year, have panic disorder.[1, 2]
- Panic disorder typically develops in early adulthood (median age of onset is 24), but the age of onset extends throughout adulthood.[5]
- About one in three people with panic disorder develops agoraphobia, a condition in which the individual becomes afraid of being in any place or situation where escape might be difficult or help unavailable in the event of a panic attack.[12]

Obsessive-Compulsive Disorder (OCD)

- Approximately 2.2 million American adults age 18 and older, or about 1.0 percent of people in this age group in a given year, have OCD.[1, 2]
- The first symptoms of OCD often begin during childhood or adolescence, however, the median age of onset is 19.[5]

Post-Traumatic Stress Disorder (PTSD)

- Approximately 7.7 million American adults age 18 and older, or about 3.5 percent of people in this age group in a given year, have PTSD.[1, 2]
- PTSD can develop at any age, including childhood, but research shows that the median age of onset is 23 years.[5]
- About 19 percent of Vietnam veterans experienced PTSD at some point after the war.[13] The disorder also frequently occurs after violent personal assaults such as rape, mugging, or domestic violence; terrorism; natural or human-caused disasters; and accidents.

Generalized Anxiety Disorder (GAD)

- Approximately 6.8 million American adults, or about 3.1 percent of people age 18 and over, have GAD in a given year.[1, 2]
- GAD can begin across the life cycle, though the median age of onset is 31 years old.[5]

Social Phobia

- Approximately 15 million American adults age 18 and over, or about 6.8 percent of people in this age group in a given year, have social phobia.[1]
- Social phobia begins in childhood or adolescence, typically around 13 years of age.[5]

Agoraphobia

Agoraphobia involves intense fear and anxiety of any place or situation where escape might be difficult, leading to avoidance of situations such as being alone outside of the home; traveling in a car, bus, or airplane; or being in a crowded area.[5]

- Approximately 1.8 million American adults age 18 and over, or about 0.8 percent of people in this age group in a given year, have agoraphobia

without a history of panic disorder.[1, 2]

- The median age of onset of agoraphobia is 20 years of age.[5]

Specific Phobia

Specific phobia involves marked and persistent fear and avoidance of a specific object or situation.

- Approximately 19.2 million American adults age 18 and over, or about 8.7 percent of people in this age group in a given year, have some type of specific phobia.[1, 2]
- Specific phobia typically begins in childhood; the median age of onset is seven years.[5]

Eating Disorders

The three main types of eating disorders are anorexia nervosa, bulimia nervosa, and binge-eating disorder.

- In their lifetime, an estimated 0.6 percent of the adult population in the U.S. will suffer from anorexia, 1.0 percent from bulimia, and 2.8 percent from a binge eating disorder. [14]
- Women are much more likely than males to develop an eating disorder. They are three times as likely to experience anorexia (0.9 percent of women vs. 0.3 percent of men) and bulimia (1.5 percent of women vs. 0.5 percent of men) during their life. They are also 75 percent more likely to have a binge eating disorder (3.5 percent of women vs. 2.0 percent of men).[14]
- The mortality rate among people with anorexia has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population.[15]

Attention Deficit Hyperactivity Disorder (ADHD)

- ADHD, one of the most common mental disorders in children and adolescents, also affects an estimated 4.1 percent of adults, ages 18-44, in a given year.[1]
- ADHD usually becomes evident in preschool or early elementary years. The

median age of onset of ADHD is seven years, although the disorder can persist into adolescence and occasionally into adulthood.[5]

Autism

Autism is part of a group of disorders called autism spectrum disorders (ASDs), also known as pervasive developmental disorders. ASDs range in severity, with autism being the most debilitating form while other disorders, such as Asperger syndrome, produce milder symptoms.

- Estimating the prevalence of autism is difficult and controversial due to differences in the ways that cases are identified and defined, differences in study methods, and changes in diagnostic criteria. A recent study by the Centers for Disease Control and Prevention (CDC) reported the prevalence of autism among 8 year-olds to be about 1 in 110.[16]
- Autism and other ASDs develop in childhood and generally are diagnosed by age three.[17]
- Autism is about four times more common in boys than girls. Girls with the disorder, however, tend to have more severe symptoms and greater cognitive impairment.[16,17]

Personality Disorders

Personality disorders represent "*an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it.*"[4] These patterns tend to be fixed and consistent across situations and are typically perceived to be appropriate by the individual even though they may markedly affect their day-to-day life in negative ways. Among American adults ages 18 and over, an estimated 9.1% have a diagnosable personality disorder.[18] Several more common personality disorders include:

Antisocial Personality Disorder

Antisocial personality disorder is characterized by an individual's disregard for social rules and cultural norms, impulsive behavior, and indifference to the rights and feelings of others.

- Approximately 1.0 percent of people aged 18 or over have antisocial personality disorder.[18]

Avoidant Personality Disorder

Avoidant personality disorder is characterized by extreme social inhibition, sensitivity to negative evaluation, and feelings of inadequacy. Individuals with avoidant personality disorder frequently avoid social interaction for fear of being ridiculed, humiliated, or disliked.

- An estimated 5.2 percent of people age 18 or older have an avoidant personality disorder.[18]

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is defined by the DSM-IV as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts."

- Approximately 1.6 percent of Americans age 18 or older have BPD.[18]

For More Information

Mental Health Information and Organizations from NLM's MedlinePlus (en Español).

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American Academy of Child and Adolescent Psychiatry

Suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt

whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the signs and symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: I won't be a problem for you much longer, Nothing matters, It's no use, and I won't see you again
- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, I want to kill myself, or I'm going to commit suicide, always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and

appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

A Primer on Childhood and Adolescent Depression

July, 2008 Dr. Nadja Reilly

Depression: An Overview

One out of every four people is affected by mental illness (APA, 1994). Worldwide, unipolar depressive disorders alone lead to 12.15% of years lived with disability, and rank as the third leading contributor to the global burden of diseases (World Health Organization, 2003). Alarmingly, depression is the fourth most important cause of impairment in work and home life, and by the year 2020 it will be the second leading cause (Beardslee, 2002).

By the year 2020, neuropyschiatric disorders will become one of the most common causes of disability among children (World Health Organization).

Sadly, these statistics are a reality not just among adults, but among children and adolescents, as well. The burden of suffering and the costs, emotionally and financially, frighteningly mirror those found among adults. In the United States, one in ten children and adolescents suffer from mental illnesses severe enough to cause some level of impairment. Yet, in any given year, only about one in five of these children will receive the specialty mental health services they need. Evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent, worldwide, to become one of the five most common causes of morbidity, mortality, and disability among children (Report of the Surgeon General's Conference on Children's Mental Health, 2000).

Today's schoolchildren are at a higher risk for depression than any previous generation. As many as 9% of children will experience a major

depressive episode by the time they are 14 years old, and 20% will experience a major depressive episode before graduating from high school. Having suffered from depression as children, these young people are much more vulnerable to depression as adults (APA, 2006).

Child and adolescent depression has been studied extensively, and is associated with many negative outcomes, including substance abuse, academic problems, substance abuse, high-risk sexual behavior, physical health problems, impaired social relationships, and an increased risk of completed suicide (Horowitz & Garber, 2006).

There is significant hope as safe and effective treatments are available for the majority of cases of depression

While these are alarming statistics, there is significant hope in that safe and effective treatments are available for the majority of cases of depression. Treatments include medication, psychotherapy, family therapy, and group therapy. In particular, cognitive, behavioral, and interpersonal therapy can have significantly positive impacts on the treatment of depression Beardslee, 2002)

Depression is a disabling disorder in Children and Adolescents

- Depression is the leading cause of disability worldwide among persons age 5 and older.
- 7-14% experience an episode of depression before the age of 15.
- 60-80% of children and adolescents with depression are undiagnosed and untreated
- One in five adolescents in US considers suicide.
- Depression directly or indirectly results in 1700 teen suicides per year.

Symptoms of Depression

Use this chart to help clarify some of the common symptoms of depression.

Category	**Symptoms**
Affective	Anxiety, depressed mood, irritable, morning depression worse than

	later in the day
Motivational	Loss of interest in activities, hopeless, helpless, suicidal thoughts or acts
Cognitive	Difficulty concentrating, worthlessness, guilt, low self-esteem, memory problems, difficulty with problem solving
Behavioral	Isolated, easily angered or agitated, oppositional, risk taking
Vegetative	Sleep problems, appetite change, weight change, energy loss, motor agitation
Somatic	Physical complaints, frequent stomachaches and headaches, body pains

Childhood Depression

- Estimates reach 2%
- Male predominant
- Somatic complaints very common
- Commonly associated with high irritability and sadness
- High co-morbidity with disruptive behavior disorders

Some of the behavioral cues associated with childhood depression include:

- Looking sad
- Weeping or crying, tearful
- Withdrawn
- Refusal to eat
- Sleep problems Poor school functioning
- Slowed movements
- Monotone voice
- Extreme sensitivity to rejection or failure
- Describe themselves in negative terms such as “I’m dumb,” “I’m stupid” or “Nobody loves me.”
- Somatic symptoms are common, for example, complaints of stomach aches, head aches, or tiredness
- Anxiety about being separated from parents or caretakers
- Increased irritability and moodiness
- Loss of interest in activities

Adolescent Depression

- Estimates reach 15-20%

- Female predominant (2:1 ratio) after puberty (mostly noted between 15-18 years)
- Somatic complaints very common (example: headaches, stomachaches, muscle and joint pain)
- Increased sadness and lack of pleasure
- High co-occurrence with anxiety and substance abuse disorders

Some of the signs and symptoms associated with adolescent depression include:

- Reports of feeling overwhelmed
- Self-injurious behaviors (example: cutting, burning)
- Hopelessness (feeling like things will never change)
- Inability to concentrate
- Sense of responsibility for negative events
- Feeling "different"
- Poor-decision making
- Substance use

Suicide

Rates

- Between 1950's and late 1970's rate of suicide among young males more than tripled and doubled for young women.
- By 1980's suicide by youth 15-24 = 17% of approximate 30,000 suicides in the US
- 1994 saw a peak at 13.6 suicides per 100,000 youth 15-24
- In 2002 rates declined to 9.9 per 100,000
- Cultural differences are noted in attempts and completed suicides
- Despite declines overall youth suicide rate remains more than 2 times what it had been prior to marked rise and currently constitutes almost 13% of all US suicides

Risk Factors

Risk factors are factors related to family history, past, or current situations that may play a role in the child's emotional health. Having one of the risk factors does not mean a child will necessarily develop a mood disorder. Mental health professionals assess the number of risk factors, as well as how they impact the child's current functioning, when evaluating a child for a mood disorder.

· Depression · Family history of suicide
· Parental psychopathology
· Hopelessness; pessimism
· Recent losses
· Stressful life events
· Social isolation
· Exposure to violence and/or trauma
· Conduct disorder in males
· Panic disorder in females
· Physical/emotional/ sexual abuse
· Drug/alcohol abuse
· Aggressive/impulsive behavior
· Firearm availability
· Diminished family cohesion
· Long term, sustained parent-child conflict
· Lack of parental support
· Suicide contagion
· Same sex sexual orientation (same sex sexual orientation in and of itself is not problematic, it is the alienation and/or rejection an adolescent may experience as a result that is problematic.)

Gender Differences Among boys, a previous suicide attempt increases the risk of a second suicide attempt by over 30 fold. Boys who are depressed are 12 times as likely to attempt suicide and those with disruptive behavior are 2 times as likely to attempt suicide.

Girls who have experienced major depression are 12 times as likely to attempt suicide. Girls who have had a previous suicide attempt are 3 times as likely to have a second suicide attempt.

Warning Signs

Warning signs are different from risk factors in that these are behaviors that one is likely to see shortly before a suicide gesture or attempt. When warning signs are evident, immediate help should be sought.

· preoccupation with death related topics
· talking about suicide
· erratic behavior changes
· giving away special things

- taking excessive risks
- increased drug/alcohol use
- decreased interest in usual activities
- increased isolation
- getting weapons

How to tell if depression is a passing change (non-clinical temporary mood distrubance) or true disturbance (dysthymia or major depression)

- How long have the symptoms lasted? (2 weeks time frame)
- How severe is the change in behavior and mood? (able to respond to distraction or intervention)
- How many areas of functioning are impaired? (impaired across family, school, peers)

Diagnostic Differences

Major Depression	**Dysthymia**
Dysphoric mood	Dysphoric mood
Symptoms severe	Symptoms mild-moderate
Impaired functioning common	Impaired functioning less common
Possible psychosis	No psychosis
Symptoms present every day	Symptoms usually fluctuating
Symptoms present every day for 2 weeks	Symptoms on and off for one year

Treatment of Depression

- Psychotherapy
  - Individual therapy (example: cognitive behavioral therapy)
  - Parent guidance
  - Family therapy
  - Group therapy
- Pharmacological Treatment
  - Selective serotonin reuptake inhibitors (SSRI's)
  - Mood stabilizers
  - Anti-psychotics (While not a common occurrence, at times children and adolescents may present with hallucinations and/or delusions as part of the symptom cluster associated

with their major depressive episode. This is diagnosed as Major Depressive Episode with Psychotic Features. When this occurs, anti-psychotic medication is used to treat the hallucinations and/or delusions.)

Outcomes Those with adolescent depression 2 to 3 times as likely to experience anxiety or depressive disorder in adulthood.

A majority of adolescents will experience at least 1 recurrence within 2 years of treatment termination.

There are poorer outcomes associated with a presence of: – Double depression – Maternal depressive symptoms – Family discord – Hopelessness – High cognitive distortion – More severe depressive symptoms at intake

Protective Factors

- Each youth's unique talents, strengths, interests, and future potential
- Resilience and coping skills
- Families described as emotionally involved and supportive
- Student connectedness to school
- Child's connection to at least one adult
- Range of social skills

Negative Thinking Patterns

- Depressed individuals have more negative beliefs about themselves, the world, and their future
- Low self-esteem, negative automatic thoughts, pessimism, hopelessness, low belief about one's self-efficacy are related to depression
- The link between negative thinking patterns and depression increases from middle childhood to early adolescence