## WHAT YOU and YOUR FAMILY SHOULD KNOW ABOUT DEPRESSION

**What is Major Depression? -** A medical illness, characterized by depression that is believed due to biochemical changes in brain function.

**Myths -** Major depression is not a trivial disorder, will not go away on its own and is not the result of personal weakness, laziness or lack of will power.

**Incidence -** Depression is one of the most common illnesses treated by health care professionals, affecting one out of every 20 people sometime in their lifetime.

**Risk Factors -** Females, people with a first degree relative with depression, people with a history of drug or alcohol abuse or people with a history of anxiety or eating disorders have an increased incidence of depression.

**Treatment Response -** Depression is very responsive to treatment through antidepressant medication, psychotherapy or a combination. People do get better.

**Medications -** All antidepressant medications take several weeks to produce their full effect.

**Medication Safety -** Antidepressants are safe when taken as prescribed and are not addicting.

**Medication Side Effects -** Discuss medication side effects or other problems with your primary care manager. Most problems can be resolved.

**Don't -** Drink alcohol, self-medicate, blame yourself or make major life decisions or changes during treatment.

**Do -** Get plenty of rest, exercise, eat regularly, socialize.

**Outpatient vs Inpatient Care -** Most depressions are successfully treated in the primary care manager's office. Inpatient hospitalization is generally reserved for patients who have delusions or hallucinations or are a danger to themselves or others.

**Consultation/Referral -** Sometimes a second opinion is required because a combination of treatments might work best, or the depression is severe or lasts a long time or the first treatment did not work well.

**Treatment Compliance -** Medication must be taken as directed, including dosage, frequency and length of time prescribed. Follow-up appointments with your primary care manager, mental health specialist or others need to be kept as scheduled.

**Suicide** - Thoughts of death often accompany depression. Always discuss this symptom with your primary care provider. If your provider is not available, tell a trusted friend or relative who can get you immediate emergency professional help.

**Communication -** Ask questions about treatment. Verbalize any concerns. Discuss with your primary care manager your feelings, activity, sleep and eating patterns, as well as unusual symptoms or physical problems.

**Recurrence -** Depression is often recurrent. Maintenance antidepressants are sometimes indicated.

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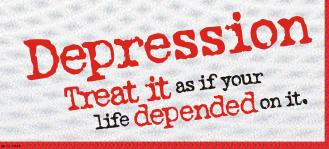


## Self-Management

A Guide for Patients







## Complete a new booklet before each appointment. Review with your Primary Care Manager.

Date/Time of <u>Today's</u> Appointmen	nt:	Date/Time of Last Appointment:	
My Primary Care Manager is:		at the	Clinic
Telephone:	Date/Time of Next Appointment:		
Since my last visit with my Prim	nary Care Manager I ha	ve had the following sy	mptoms: (Check all that apply)
Depressed Mood	Feelings of Guilt	☐ Weight Loss	☐ Insomnia
Little Interest/Pleasure	☐ Crying Spells	☐ Weight Gain	Sleeping Too Much
Feelings of Worthlessness	Indecisiveness	Hopelessness	☐ Homicidal Ideation
☐ Fatigue/Loss of Energy	Poor Concentration	n 🗌 Suicidal Ideas	Suicidal Plans
Other Symptoms:			
Health Care Concerns: I want to	discuss the following co	oncerns with my Primary	Care Manager:
Medication Information: My antidepressant medication is:		mg, taken at the	ese times:
Side Effects I am experiencing:			
Other medications I am taking:			
Educational Resources: I will re  CD-ROM "Taking Control of Dep			bout depression: Other:
☐ Medication Information Hando	out Depression	Video	Other:
Referral Services: I will keep the	following appointments.	if scheduled. Write in a	appointment date and time.
Behavioral Health:	Behavioral Health: Chaplain/Minister:		
Case Management Services:_	Substance Abuse Program:		
Other Referral:			
Supportive Family or Friends:	Fill in Name and Telepho	ne Number:	
Name:	_ Phone:	Name:	Phone:
Emergency Contacts: Fill in Tele	ephone Number:		
Emergency Dept:	Crisis Cent	er: [	Police/EMS:
	relative or call an emerg	ency contact in the eve	ent I experience serious medication
Instructions from My Primary C	are Manager:		
			Signature of Patient / Date