Part of the training course
"Comprehensive Understanding and Management of Depression Disorder – A primary care approach."
hosted by School of Humanities and Social Sciences (SHSS) at Badr University in Cairo (BUC).
12/01/2025, h. 10 – 13.

INTRODUCTION TO DEPRESSION

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Stefania.muzi@unige.it

SEMINAR CONTENTS – 12/01/2025

OVERVIEW:
What is depression?

STIGMA:
Social misconceptions

QUIZ

NOSOGRAPHY:
Main diagnostic categories

EPIDEMIOLOGY:
Prevalence and demographics

WHAT IS DEPRESSION?

APA videos (1 and 2 minutes)

https://youtu.be/bTD8oK9hHXY

https://www.youtube.com/watch?v=yEGVmiudF-o

AMERICAN PSYCHOLOGICAL ASSOCIATION

APA Dictionary of Psychology

depression

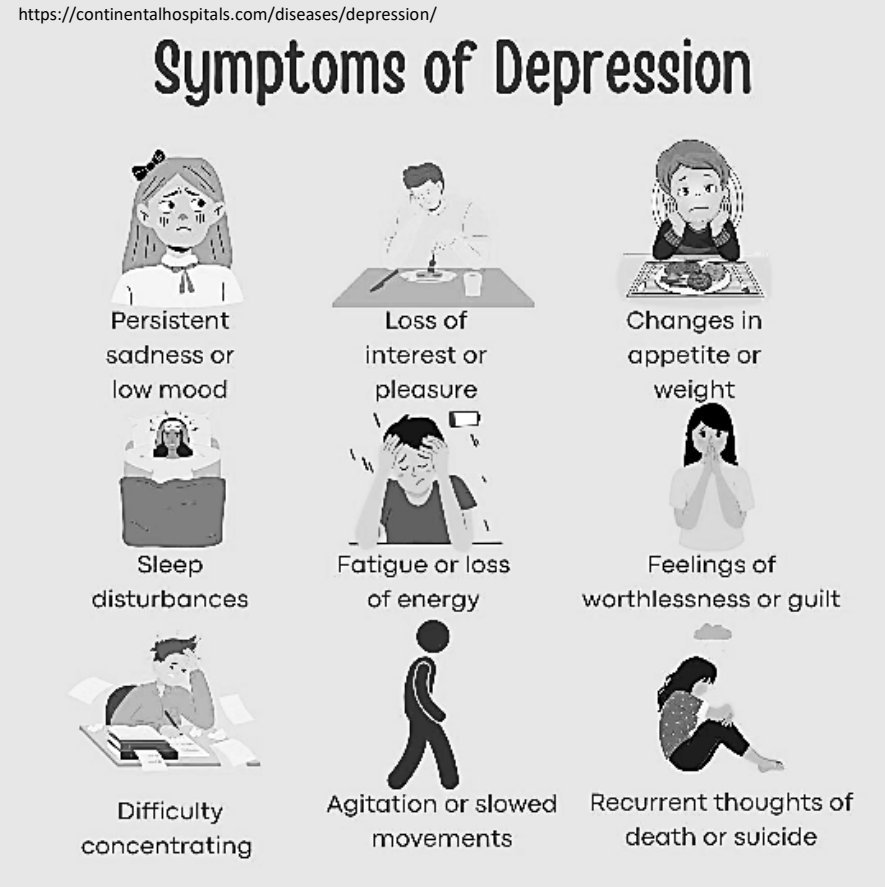
n.

1. a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life. Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities. It is symptomatic of a number of mental health disorders.

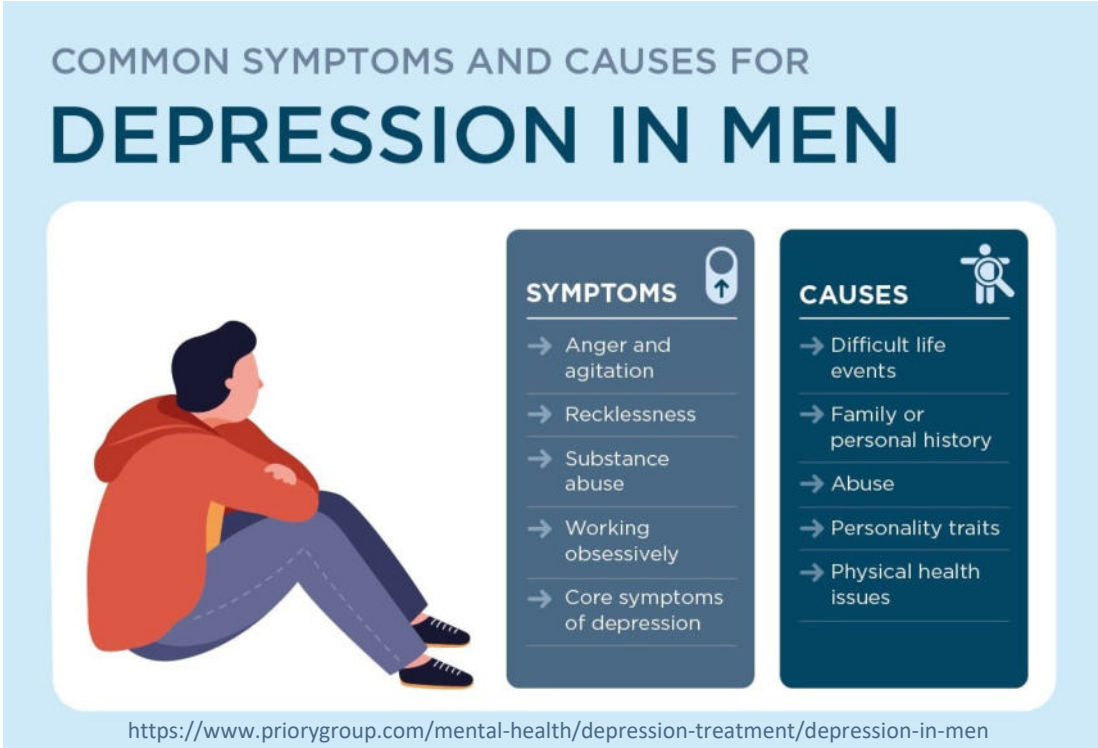
2. in psychiatry and psychology, any of the depressive disorders. **—depressed** *adj.*

CORE SYMPTOMS OF DEPRESSION

https://continentalhospitals.com/diseases/depression/



BUT… mind potential <u>gender specificities</u>!



https://www.priorygroup.com/mental-health/depression-treatment/depression-in-men

NOSOGRAPHY

DSM NOSOGRAPHY OF DEPRESSIVE DISORDERS

Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association)

DSM-IV	DSM-5-TR
Class: Mood disorders	Class: Depressive Disorders
1. Major Depressive Disorder (MDD)	= **1. Major Depressive Disorder (MDD), i.e., unipolar**
2. Dysthymic disorder	→ **2. Persistent Depressive Disorder**
3. Depressive disorder Not Otherwise Specified (NOS)	→ **3. Other specified or unspecified depressive disorder** e.g. other specified disorder: - Premenstrual dysphoric disorder (only females); - Depressive disorder due to another medical condition (*e.g.*, Parkinson disease, hypothyroidism, dementia) - Substance-/medication-induced depressive disorder. Exclusions: - anxiety or bipolar disorders; - Prolonged grief disorder; - substance use disorders; - symptoms with onset in peripartum or seasonal affective disorder - personality disorders (only with 2.)

DSM NOSOGRAPHY OF DEPRESSIVE DISORDERS

International Classification of Diseases (ICD, World Health Organization)

ICD-10	ICD-11
Class: F32-34 and F38.1 in Mood (affective) disorders	Class: Depressive disorders in Mood disorders
1. F32 - Depressive episode (from mild to severe)	**1. 6A70 - Single episode depressive disorder**
2. F33 - Recurrent depressive disorder	**2. 6A71 - Recurrent depressive disorder**
3. F34.1 Dysthymia	**3. 6A72 - Dysthymic disorder**
4. F38.1 Other recurrent mood [affective] disorders	**4. 6A7Y - Other specified depressive disorders**
	5. 6A7Z - Depressive disorders, unspecified (NOS)
	6. 6A73 – Mixed depressive and anxiety disorder
	7. GA34.41 Premenstrual Dysphoric Disorder
	Exclusions: - Acute stress reaction; - Uncomplicated bereavement; - Adjustment disorder (6B43); - Bipolar or related disorders(6A60-6A6Z)
https://icd.who.int/browse10/2019/en#/F32	https://icd.who.int/browse/2024-01/mms/en#1563440232%2Fother

DSM vs. ICD DEPRESSIVE DISORDERS

Correspondence of disorders in the two manuals

DSM-5-TR	ICD-11
Depressive episode	→ **6A70 - Single episode depressive disorder**
Major Depressive Disorder (MDD), *i.e.,* unipolar	→ **6A71 - Recurrent depressive disorder**
Persistent Depressive Disorder	→ **6A72 - Dysthymic disorder**
Other specified or unspecified depressive disorder	→ **6A7Y - Other specified depressive disorders** **6A7Z - Depressive disorders, unspecified (NOS)**
e.g. other specified disorder: - Premenstrual dysphoric disorder (only females); - Depressive disorder due to another medical condition (*e.g.*, Parkinson disease, hypothyroidism, dementia) - Substance-/medication-induced depressive disorder.	

DEPRESSIVE EPISODE

Depressive mood lasting and/or loss of interest and pleasure nearly every day, for most of the day for at least <u>two consecutive weeks</u>. It represents a change from normal functioning and differs from normal mood fluctuations.

Prodromic signs and symptoms:
- Not-depressive symptoms: anxiety, irritability, anhedonia, sleep disturbances;
- Depressive symptoms: sadness, subthreshold depression;
- Mild but impairing changes in functioning (irritable mood or school refusal in children);

≠ **demoralisation** (→ only hopelessness, no significative impairments);
≠ **irritable mood** (e.g., lose the temper with no relief later)
≠ **acute stress reaction**
≠ **Loss reaction,** i.e., complicated bereavement (>1 year), financial ruin, natural disaster, serious medical illness or disability, etc. (→ self esteem maintained, occasional positive feelings)

MAJOR DEPRESSIVE DISORDER (MDD)

A. **Five (or more) depressive symptoms**, **lasting most of the day for at least two weeks**, of which one is either (1) depressive mood (observed by the self and the others) or (2) loss of interest and pleasure. Other symptoms: (3) ± 5% weight loss or gain; (4) Insomnia or hypersomnia every day; (5) psychomotor agitation or retardation every day, as reported by others; (6) fatigue or loss of energy nearly every day; (7) Persistent feelings of worthlessness or excessive, possibly delusional guilt occur almost every day, beyond mere self-reproach or guilt about illness. (8) Nearly daily diminished ability to think, concentrate, or indecisiveness is noted by the person and others; (9) recurrent thoughts of death, suicidal ideation without a plan, or previous suicide attempts.

B. **Symptoms cause clinically significant distress or impairment in different life areas (social, occupational, etc.).**

C. **Episode(s) not attributable to direct physiological effects of a substance or another medical condition.**

D. MDD cannot be diagnosed if the depressive episode is better explained by any schizophrenic or psychotic disorder;

E. There has never been a manic or hypomanic episode.

≠ single depressive episode
≠ acute stress reaction
≠ any loss reaction (complicated bereavement, financial ruin, natural disaster, serious medical illness or disability, etc.).

PERSISTENT DEPRESSIVE DISORDER (PDD)

A. A 2-year (or longer) period of depressed mood, most of the day, for more days than not.

B. At least 2 of the following symptoms: (1) Poor appetite or overeating; (2) Insomnia or hypersomnia; (3) Low energy or fatigue; (4) Low self-esteem; (5) Poor concentration or difficulty making decisions; (6) Feelings of hopelessness;

C. During a 2-year period (1 year for children or adolescents), the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a MDD may be continuously present for 2 years*.

E. There has never been a manic or hypomanic episode.

F. The disturbance is not better explained by a schizophrenia spectrum or other psychotic disorder.

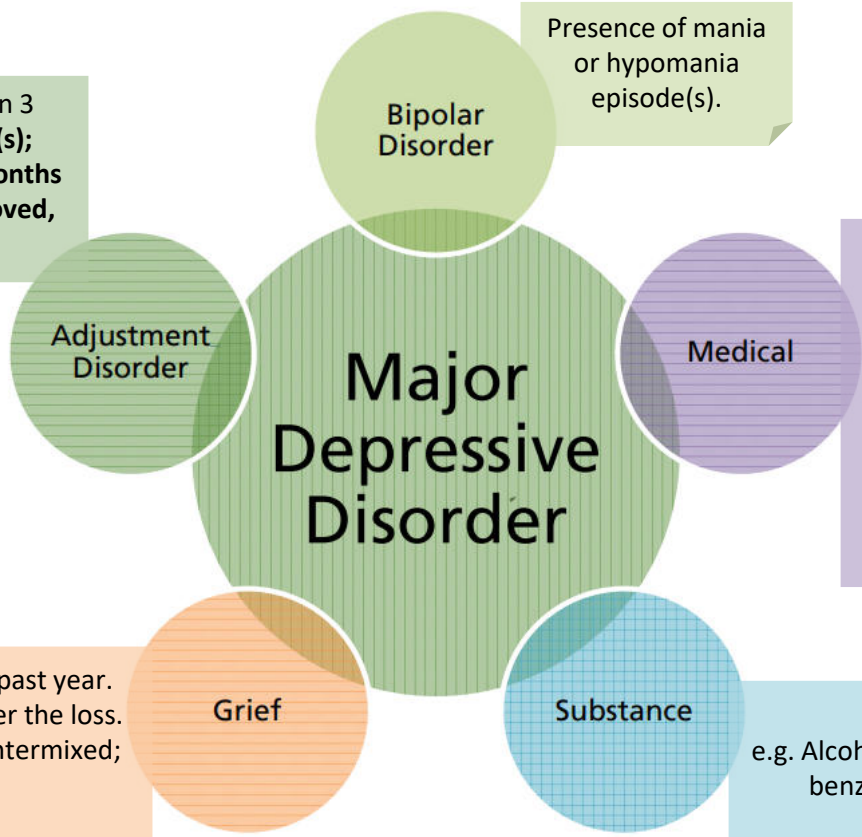
G. The symptoms are not attributable to the physiological effects of a substance or another medical condition.

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*** ≠ dysthymic disorder** in DSM-IV, the **additional diagnosis of MDD** should be made if the criteria are met for MDD during the time period for PDD.

DIFFERENTIAL DIAGNOSES

DIFFERENTIAL DIAGNOSIS MDD



Presence of mania or hypomania episode(s).

- Symptoms occurred within 3 months of **known stressor(s);**
- **Symptoms decrease in 6 months if the stressor(s) is/are removed,**

Preventive medical examination does not attribute symptoms to a medical condition, e.g.:

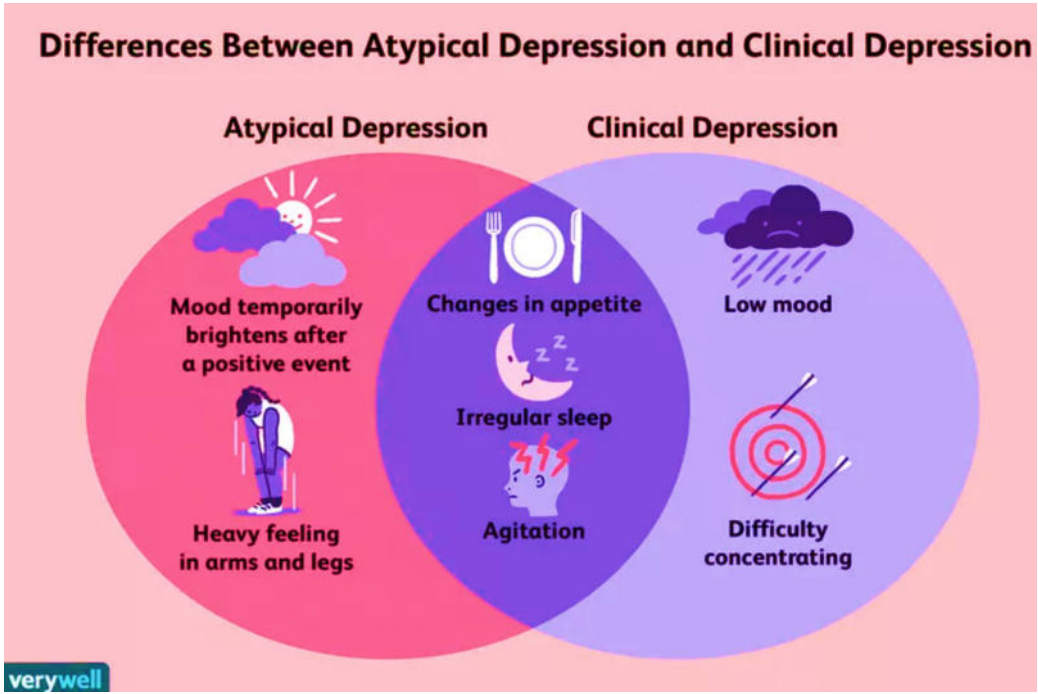
Hypothyroidism, Cushing syndrome, Multiple sclerosis, Parkinson disease, Traumatic brain injury, Stroke, Huntington disease, Autoimmune disorders, Heart failure, COPD, HIV infection, Cancer, Hypoglycemia (and diabetes).

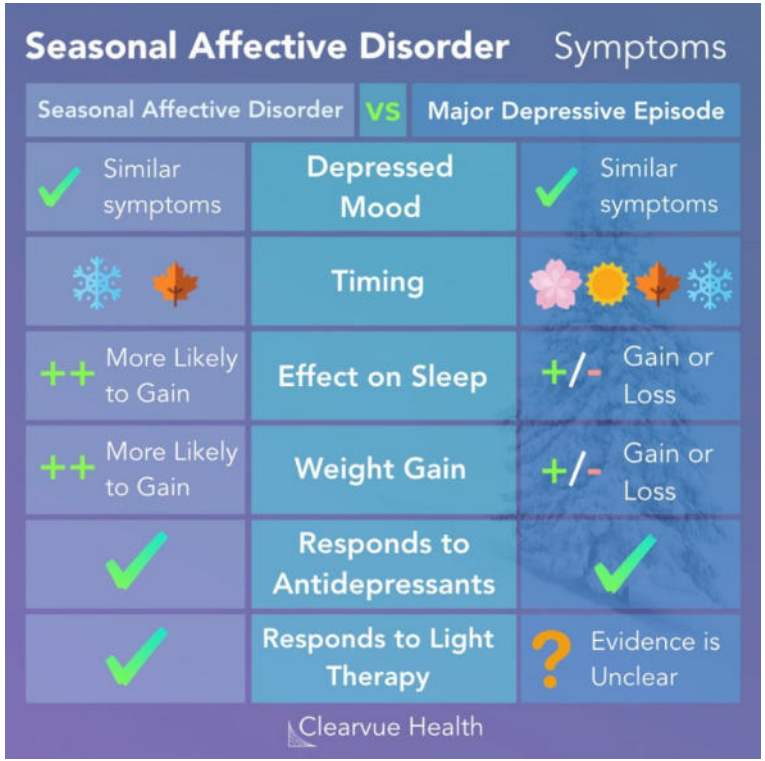
- **Loss of a significant person** in the past year.
- Symptoms last 2 months or less after the loss.
- Painful and positive emotions are intermixed;
- Preserved self-esteem.

Recreational* and/or prescribed use of drugs,
e.g. Alcohol, opioids (including heroin), cannabinoids (marijuana), benzodiazepines,, amphetamines, caffeine and cocaine.
***Mind the alliance here, difficult to assess!**

https://img3.reoveme.com/m/95dab8cbf0e619e9.pdf

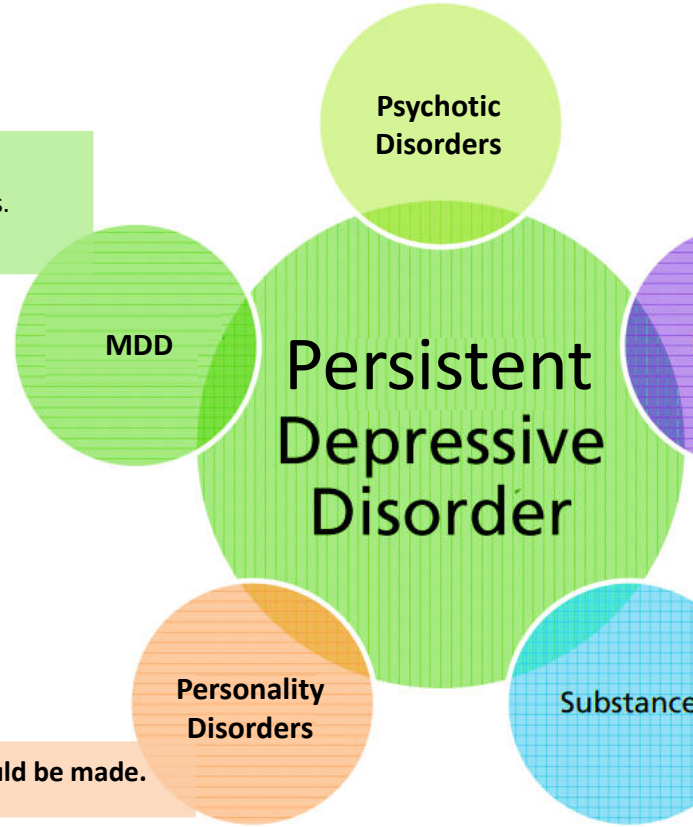
OTHER DIFFERENTIAL DIAGNOSES MDD





https://www.clearvuehealth.com/sadsymptoms/

DIFFERENTIAL DIAGNOSIS PDD



- 5 or more symptoms;
- Lenght and/or severity symptoms.

Bipolar or MDD due to other medical condition.

Preventive medical examination does not attribute symptoms to a medical condition, e.g.: Hypothyroidism, Cushing syndrome, Multiple sclerosis, Parkinson disease, Traumatic brain injury, Stroke, Huntington disease, Autoimmune disorders, Heart failure, COPD, HIV infection, Cancer, Hypoglycemia (and diabetes).

In this case, both diagnoses should be made.

Recreational* and/or prescribed use of drugs,
e.g. Alcohol, opioids (including heroin), cannabinoids (marijuana), benzodiazepines,, amphetamines, caffeine and cocaine.
***Mind the alliance here, difficult to assess!**

https://img3.reoveme.com/m/95dab8cbf0e619e9.pdf

Patel, R., Aslam, S., & Rose, G. (2024). Persistent depressive disorder. StatPearls.

TIPS FOR THE DIAGNOSTIC PROCESS

1. Exclude any medical condition.

- Ask questions about existing medical conditions (also in relatives)
- Prescribe or ask colleagues for comprehensive medical check

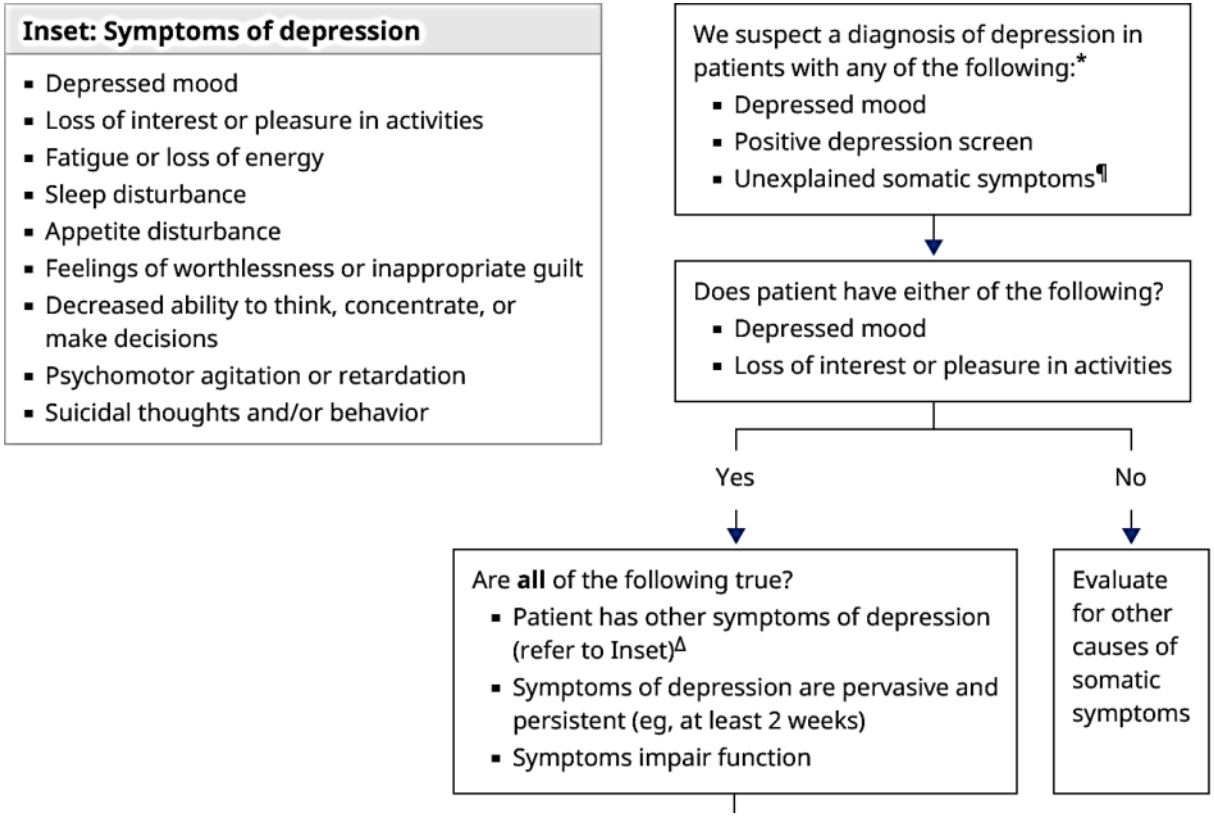
2. Screen for depressive symptoms

- Screening questionnaires (also for suicidality, e.g., PHQ-9);
- Interview with focus on checking symptoms (length, possible causes, risks and resources);

3. Screen for other symptoms and try a differential diagnosis.

https://www.uptodate.com/contents/image?imageKey=PSYCH%2F59307&topicKey=PC%2F1721&source=see_link

SUGGESTIONS FOR THE SCREENING PROCESS(1)



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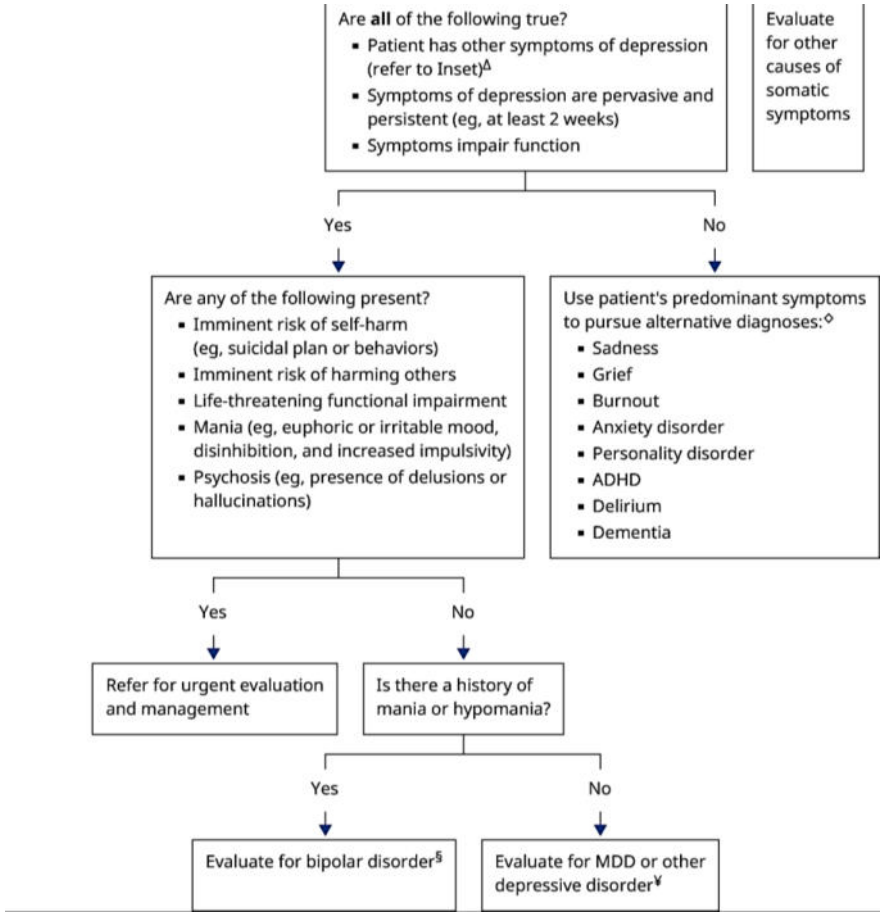
SUGGESTIONS FOR THE SCREENING PROCESS(2)



https://www.uptodate.com/contents/image?imageKey=PC%2F145197&topicKey=PC%2F1721&source=inline_graphic

RESOURCES FOR PRIMARY HEALTHCARE SETTINGS

https://doi.org/10.7326/0003-4819-151-11-200912010-00007

Screening for Depression in Adult Patients in Primary Care Settings: A Systematic Evidence Review FREE

Authors: Elizabeth A. O'Connor, PhD, Evelyn P. Whitlock, MD, MPH, Tracy L. Beil, MS, and Bradley N. Gaynes, MD, MPH

Research | Open access | Published: 24 February 2023 https://doi.org/10.1186/s13643-023-02177-6

Interventions to improve the detection of depression in primary healthcare: systematic review

Kassahun Habtamu, Rahel Birhane, Mekdes Demissie & Abebaw Fekadu

Systematic Reviews **12**, Article number: 25 (2023) | Cite this article

Fekadu *et al. Systematic Reviews* (2022) 11:21
https://doi.org/10.1186/s13643-022-01893-9

Systematic Reviews

https://doi.org/10.1186/s13643-022-01893-9

SYSTEMATIC REVIEW UPDATE Open Access

Under detection of depression in primary care settings in low and middle-income countries: a systematic review and meta-analysis

Abebaw Fekadu[1,2,3,4*], Mekdes Demissie[2], Rahel Birhane[2], Girmay Medhin[5], Tesera Bitew[2,6], Maji Hailemariam[2,7], Abebaw Minaye[8], Kassahun Habtamu[8], Barkot Milkias[2], Inge Petersen[9], Vikram Patel[10], Anthony J. Cleare[4], Rosie Mayston[11], Graham Thornicroft[12,13], Atalay Alem[2], Charlotte Hanlon[2,12] and Martin Prince[11,12]

Systematic review update | Open access | Published: 31 January 2024

Screening for depression in children and adolescents in primary care or non-mental health settings: a systematic review update

Andrew Beck, Nicole Dryburgh, Alexandria Bennett, Nicole Shaver, Leila Esmaeilisaraji, Becky Skidmore, Scott Patten, Heather Bragg, Ian Colman, Gary S. Goldfield, Stuart Gordon Nicholls, Kathleen Pajer, Robert Meeder, Priya Vasa, Beverley J. Shea, Melissa Brouwers, Julian Little & David Moher

Systematic Reviews **13**, Article number: 48 (2024) *https://doi.org/10.1186/s13643-023-02447-3*

ELSEVIER

Journal of Affective Disorders
Volume 225, 1 January 2018, Pages 503-522

https://doi.org/10.1016/j.jad.2017.08.060

Review article

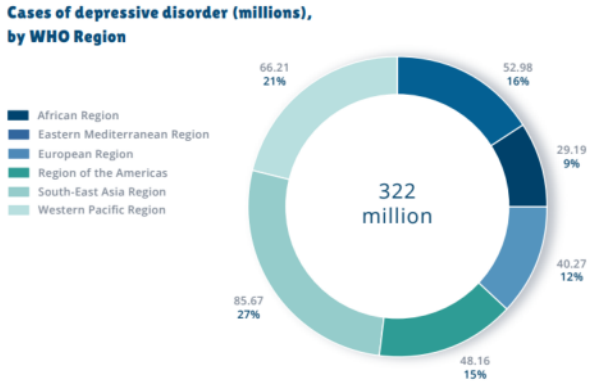
The psychometric properties of depression screening tools in primary healthcare settings: A systematic review

Sarira El-Den, Timothy F. Chen, Yuh-Lin Gan, Eling Wong, Claire L. O'Reilly

EPIDEMIOLOGY

PREVALENCE OF DEPRESSIVE DISORDERS

- Global **prevalence of depression in adults is around 5%** (WHO, 2023)
- **In adolescents**, one-year prevalence of **MDD is around 8%** and lifetime 19%, and one-year prevalence of **PDD is 4%** (Shorey et al., 2021).
- **Females experienced more depressive symptoms than males in any age group.**



A All ages

Leading causes 1990	Percentage of DALYs 1990	Leading causes 2019	Percentage of DALYs 2019	Percentage change in number of DALYs, 1990–2019	Percentage change in age-standardised DALY rate, 1990–2019
1 Neonatal disorders	10·6 (9·9 to 11·4)	1 Neonatal disorders	7·3 (6·4 to 8·4)	−32·3 (−41·7 to −20·8)	−32·6 (−42·1 to −21·2)
2 Lower respiratory infections	8·7 (7·6 to 10·0)	2 Ischaemic heart disease	7·2 (6·5 to 7·9)	50·4 (39·9 to 60·2)	−28·6 (−33·3 to −24·2)
3 Diarrhoeal diseases	7·3 (5·9 to 8·8)	3 Stroke	5·7 (5·1 to 6·2)	32·4 (22·0 to 42·2)	−35·2 (−40·5 to −30·5)
4 Ischaemic heart disease	4·7 (4·4 to 5·0)	4 Lower respiratory infections	3·8 (3·3 to 4·3)	−56·7 (−64·2 to −47·5)	−62·5 (−69·0 to −54·9)
5 Stroke	4·2 (3·9 to 4·5)	5 Diarrhoeal diseases	3·2 (2·6 to 4·0)	−57·5 (−66·2 to −44·7)	−64·6 (−71·7 to −54·2)
6 Congenital birth defects	3·2 (2·3 to 4·8)	6 COPD	2·9 (2·6 to 3·2)	25·6 (15·1 to 46·0)	−39·8 (−44·9 to −30·2)
7 Tuberculosis	3·1 (2·8 to 3·4)	7 Road injuries	2·9 (2·6 to 3·0)	2·4 (−6·9 to 10·8)	−31·0 (−37·1 to −25·4)
8 Road injuries	2·7 (2·6 to 3·0)	8 Diabetes	2·8 (2·5 to 3·1)	147·9 (135·9 to 158·9)	24·4 (18·5 to 29·7)
9 Measles	2·7 (0·9 to 5·6)	9 Low back pain	2·5 (1·9 to 3·1)	46·9 (43·3 to 50·5)	−16·3 (−17·1 to −15·5)
10 Malaria	2·5 (1·4 to 4·1)	10 Congenital birth defects	2·1 (1·7 to 2·6)	−37·3 (−50·6 to −12·8)	−40·0 (−52·7 to −17·1)
11 COPD	2·3 (1·9 to 2·5)	11 HIV/AIDS	1·9 (1·6 to 2·2)	127·7 (97·3 to 171·7)	58·5 (37·1 to 89·2)
12 Protein-energy malnutrition	2·0 (1·6 to 2·7)	12 Tuberculosis	1·9 (1·7 to 2·0)	−41·0 (−47·2 to −33·5)	−62·8 (−66·6 to −58·0)
13 Low back pain	1·7 (1·2 to 2·1)	13 Depressive disorders	1·8 (1·4 to 2·4)	61·1 (56·9 to 65·0)	−1·8 (−2·9 to −0·8)
14 Self-harm	1·4 (1·2 to 1·5)	14 Malaria	1·8 (0·9 to 3·1)	−29·4 (−56·9 to 6·6)	−37·8 (−61·9 to −6·2)
15 Cirrhosis	1·3 (1·2 to 1·5)	15 Headache disorders	1·8 (0·4 to 3·8)	56·7 (52·4 to 62·1)	1·1 (−4·2 to 2·9)
16 Meningitis	1·3 (1·1 to 1·5)	16 Cirrhosis	1·8 (1·6 to 2·0)	33·0 (22·4 to 48·2)	−26·8 (−32·5 to −19·0)
17 Drowning	1·3 (1·1 to 1·4)	17 Lung cancer	1·8 (1·6 to 2·0)	69·1 (53·1 to 85·4)	−16·2 (−24·0 to −8·2)
18 Headache disorders	1·1 (0·2 to 2·4)	18 Chronic kidney disease	1·6 (1·5 to 1·8)	93·2 (81·6 to 105·0)	6·3 (0·2 to 12·4)
19 Depressive disorders	1·1 (0·8 to 1·5)	19 Other musculoskeletal	1·6 (1·2 to 2·1)	128·9 (122·0 to 136·3)	30·7 (27·6 to 34·3)

Shorey, S., Ng, E. D., & Wong, C. H. (2022). Global prevalence of depression and elevated depressive symptoms among adolescents: A systematic review and meta-analysis. *British Journal of Clinical Psychology*, *61*(2), 287-305. https://doi.org/10.1111/bjc.12333

PREVALENCE POST COVID-19

THE LANCET

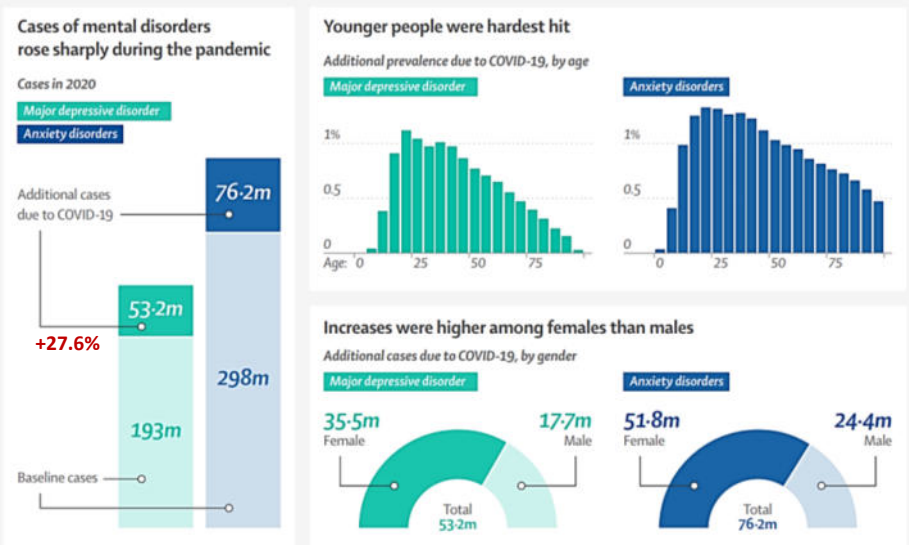
MDD has provoked 49.4 million DALYs (Disability Adjusted Life Years), i.e., years lost due to disability.

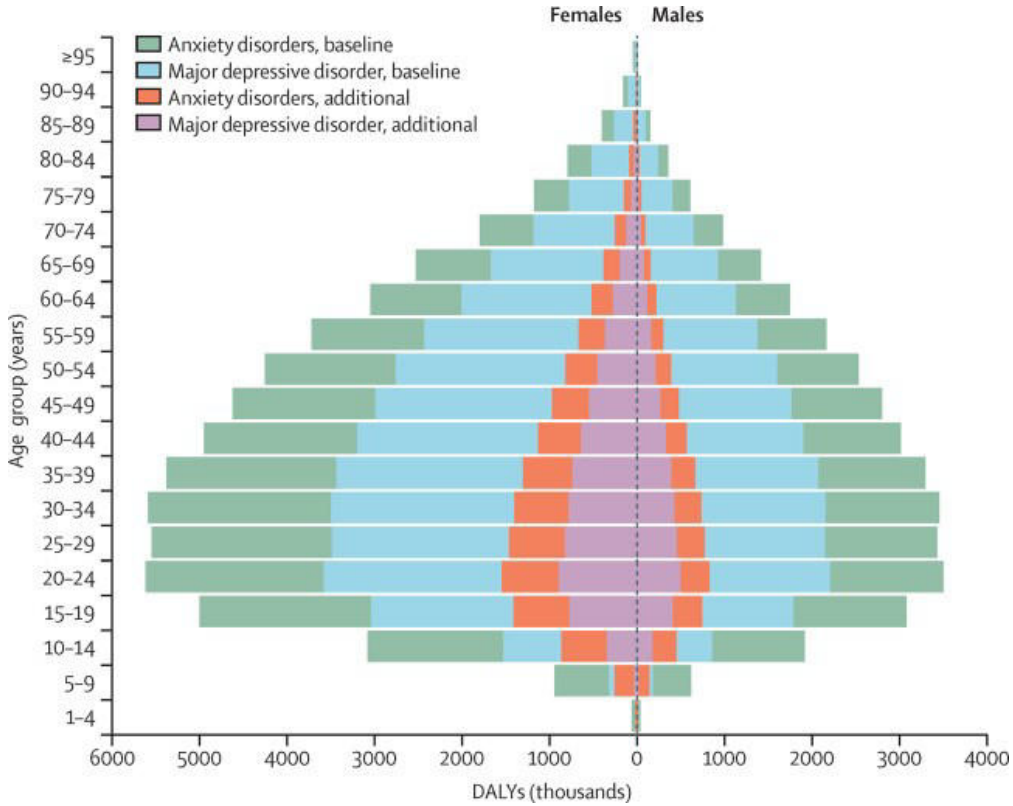
https://doi.org/10.1016/S0140-6736(21)02143-7

ARTICLES · Volume 398, Issue 10312, P1700-1712, November 06, 2021 · *Open Access*

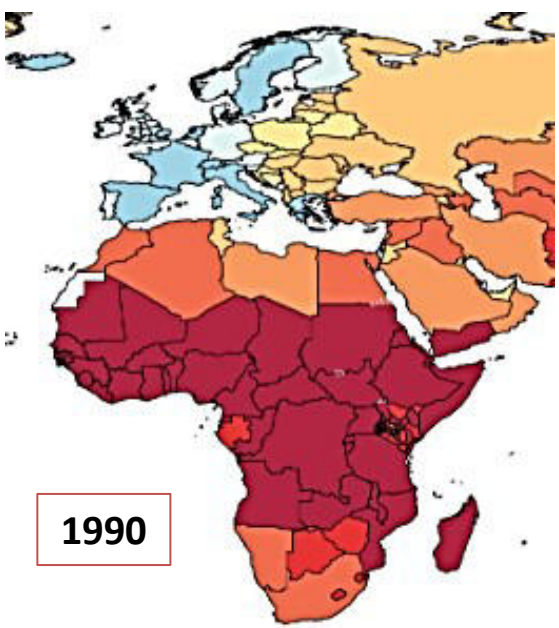
Download Full Issue

Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic

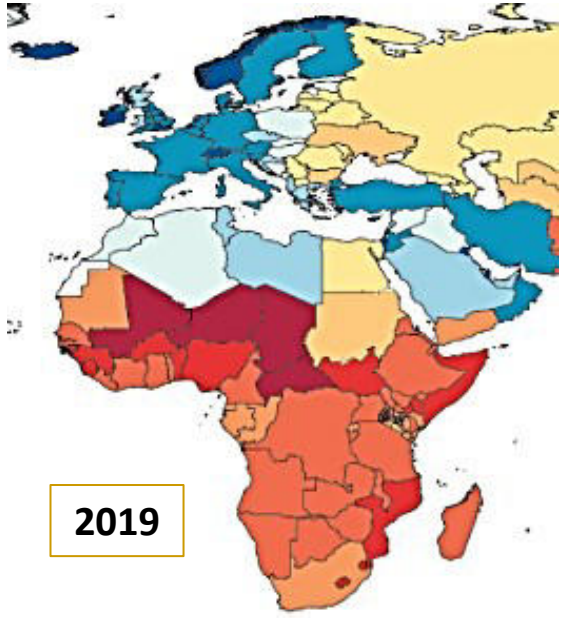




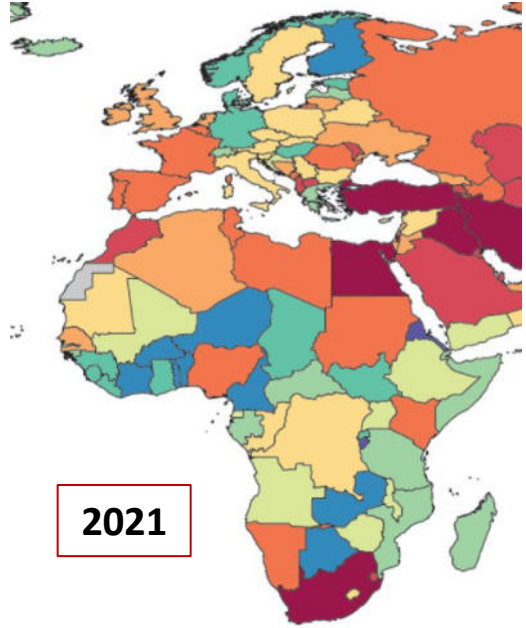
PREVALENCE OF ANY DISORDERS IN EGYPT



1990



2019



2021

YLD proportion of DALYs

<10%	30% to 34%
10% to 14%	35% to 39%
15% to 19%	40% to 44%
20% to 24%	45% to 49%
25% to 29%	≥50%

The prevalence of disorders in Egypt has increased +38.7% after the COVID-19 pandemic

Percentage change in prevalence

<10·1%	22·1% to <25·4%
10·1% to <13·6%	25·4% to <29·2%
13·6% to <17·3%	29·2% to <35·0%
17·3% to <19·2%	35·0% to <38·7%
19·2% to <22·1%	≥38·7%

PREVALENCE OF MDD IN EGYPT

https://applications.emro.who.int/emhj/1501/15_1_2009_0065_0075.pdf?ua=1

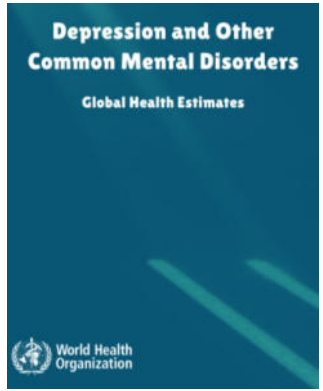
Eastern Mediterranean Health Journal, Vol. 15, No. 1, 2009

National Survey of Prevalence of Mental Disorders in Egypt: preliminary survey

M. Ghanem,[1] M. Gadallah,[2] F.A. Meky,[2] S. Mourad[3] and G. El-Kholy[1]

2006
MDD 2.70% PDD 1.03%

https://iris.who.int/bitstream/handle/10665/254610/w?sequence=1



2015
Depressive disorders 3.50%

THE LANCET

Supplementary appendix

This appendix formed part of the original submission and has been peer reviewed. We post it as supplied by the authors.

Supplement to: COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet* 2021; published online Oct 8. http://dx.doi.

http://dx.doi. org/10.1016/S0140-6736(21)02143-7

2020
MDD ~6.16%

RISK FACTORS: META-ANALYTIC HIGH EVIDENCE

https://doi.org/10.1016/j.jpsychires.2018.05.020

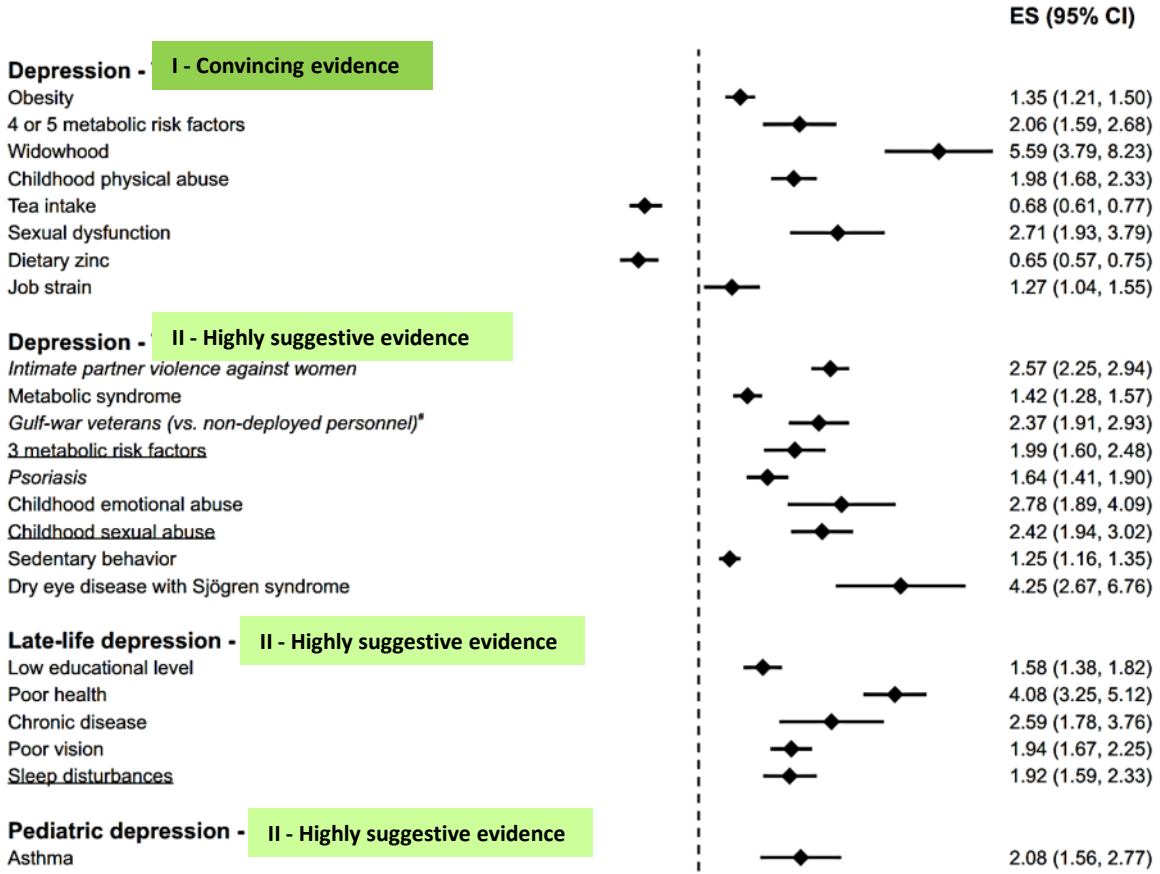
ELSEVIER

Journal of Psychiatric Research
Volume 103, August 2018, Pages 189-207

Mapping risk factors for depression across the lifespan: An umbrella review of evidence from meta-analyses and Mendelian randomization studies

Cristiano A. Köhler [a], Evangelos Evangelou [b c], Brendon Stubbs [d e f g], Marco Solmi [g h], Nicola Veronese [g i], Lazaros Belbasis [b], Beatrice Bortolato [g], Matias C.A. Melo [a], Camila A. Coelho [a], Brisa S. Fernandes [j k], Mark Olfson [l], John P.A. Ioannidis [m], André F. Carvalho [g n o]

Criteria for levels of evidence:
I – meta-analysis or 2+ RCTs with adequate sample size and placebo control
II – meta-analysis or 2+ RCTs with adequate sample size
III – small samples RCTs or nonrandomised, controlled prospective, case series or high-quality retrospective studies
IV – Expert opinion/consensus



RISK FACTORS: LEVEL III AND IV EVIDENCE

https://doi.org/10.1177/0706743716659418

Clinical Factors	Symptom Factors
• History of depression • Family history of depression • Psychosocial adversity • High users of the medical system • Chronic medical conditions (especially cardiovascular disease, diabetes, and neurological disorders) • Other psychiatric conditions • Times of hormonal challenge (e.g., peripartum)	• Unexplained physical symptoms • Chronic pain • Fatigue • Insomnia • Anxiety • Substance abuse

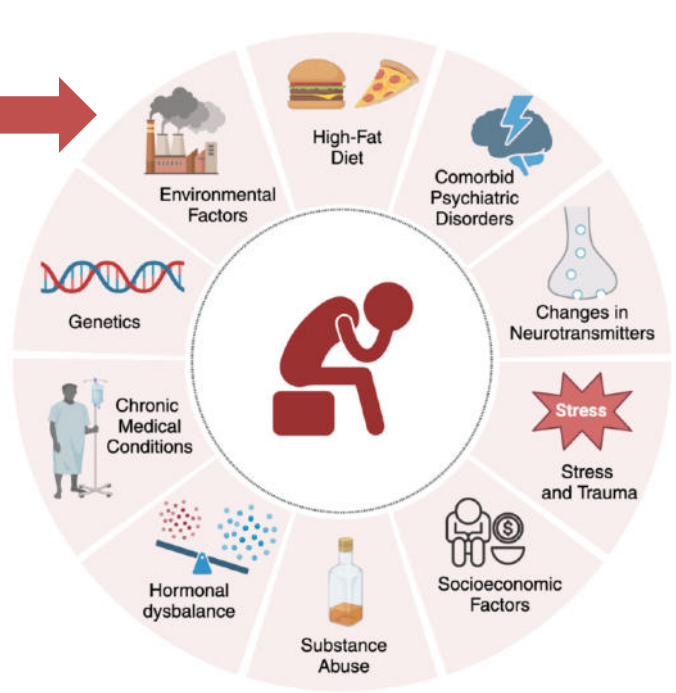
Criteria for levels of evidence:
I – meta-analysis or 2+ RCTs with adequate sample size and placebo control
II – meta-analysis or 2+ RCTs with adequate sample size
III – small samples RCTs or nonrandomised, controlled prospective, case series or high-quality retrospective studies
IV – Expert opinion/consensus

Int J Prev Med. 2021 Jul 29;12:95. doi: 10.4103/ijpvm.IJPVM_237_19

Neurological and Psychological Determinants of Depression, Anxiety, and Life Quality

Mosad Zineldin [1,✉]

EXTERNAL CONTROL OF OTHERS OVER OWN LIFE

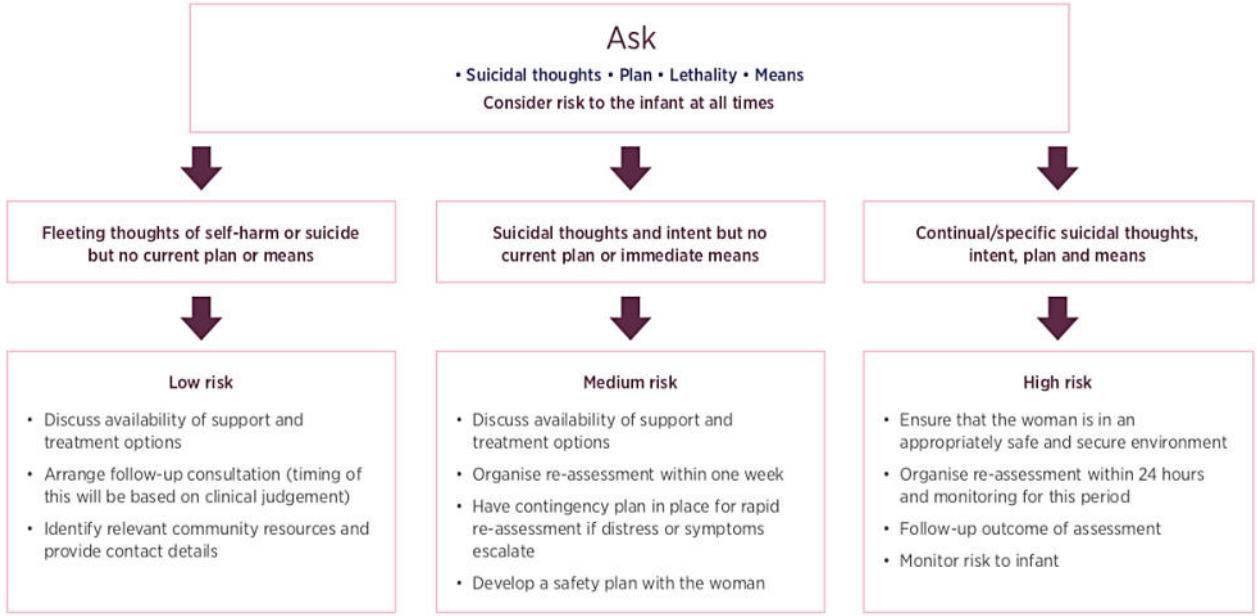


RESOURCES TO SCREEN SUICIDAL RISK

CONNECT IN EGYPT, HOTLINE FOR SUICIDE PREVENTION

Befrienders Cairo
61 Al Zahara St
Jeddah St
Mohyaldeen, Muhandesen
CAIRO
Hotline: 762 1602/3
Hotline: 762 2381
Website: befrienderscairo.com
E-mail helpline: befrienders@befrienderscairo.com

https://www.cope.org.au/health-professionals/health-professionals-3/risk-suicide

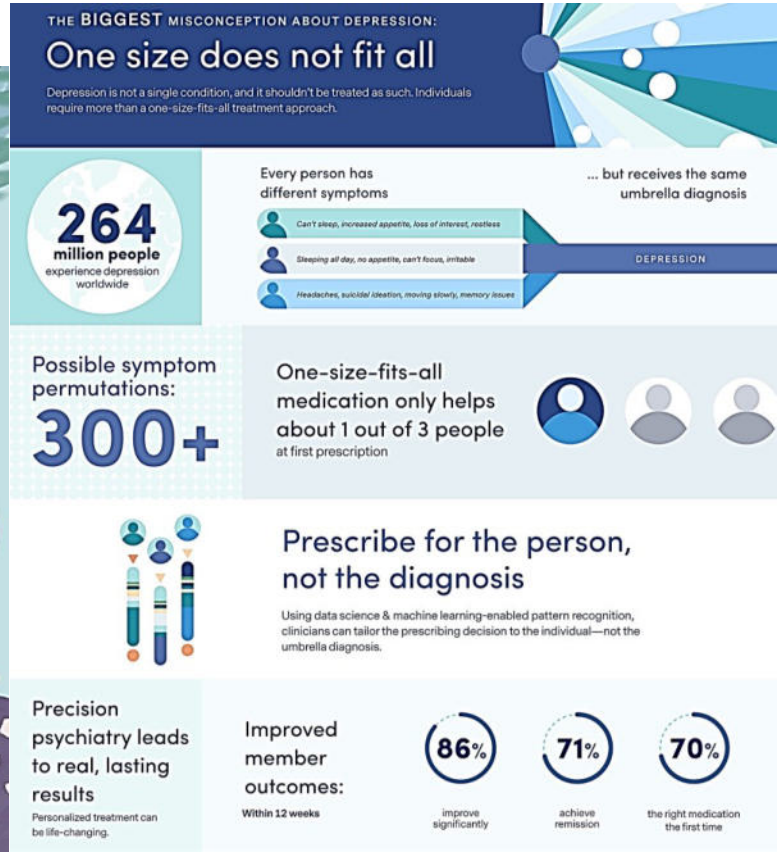


Video Suicide screening training: https://www.nimh.nih.gov/news/media/2019/suicide-risk-screening-training-how-to-manage-patients-at-risk-for-suicide

Suicide screening questions: https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_0.pdf

STIGMA AND MYTHS ON DEPRESSION

STIGMA & MISCONCEPTIONS ABOUT DEPRESSION



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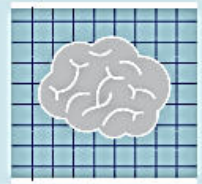
MYTHS vs. FACTS ABOUT DEPRESSION

MYTH #1:	Depression will not affect me.
FACT:	Depression is more common than you may think. In the US, more than 17 million adults live with depression yet less than half get treatment. While you may not experience depression, chances are you know someone who does.

MYTH #2:	Depression and sadness are the same and people can just snap out of it.
FACT:	Being sad is not the same as having depression. Depression is a mental health condition that causes people to experience extreme sadness, trouble sleeping, loss of energy, difficulty thinking, and more.



MYTH #3:	People's genetics dictate whether they develop depression.
FACT:	Depression is caused by one or more factors, including biological factors, life experiences, family history, personality, and environment.

MYTH #4:	People with depression cannot work in demanding or stressful jobs.
FACT:	People with depression hold jobs in diverse fields and at all levels of organizations, from the shop floor to the c-suite. Depression impacts people's work and personal lives differently. There is no "one size fits all."

MYTH #5:	Those impacted by depression do not recover.
FACT:	With proper treatment, usually consisting of medication, psychotherapy or a combination of both, people with depression can and do get better! Early and effective treatment leads to the best results.

https://workplacementalhealth.org/employer-resources/infographics/infographic-five-myths-and-facts-about-depression

QUIZ: MYTHS AND FACTS

https://medlineplus.gov/ency/quiz/003213_30.htm?quiz=1

THANK YOU! QUESTIONS?

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