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A survey of the effect pharmacotherapy and to use pleasant events of depressed womans in Iran

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ABSTRACT

Depression is highly variable in terms of presentation of symptoms and the duration of these symptoms. It is characterised by a loss of positive affect and interest in activities and can be differentiated from depressed or sad mood by being more persistent and intense and by being accompanied with cognitive, behavioural and physiological changes as well as functional and social impairment (NICE, 2004) Some of the symptoms a client with depression may experience are lack of joy (anhedonia), loss of feelings (apathy) a feeling of hopelessness, social withdrawal social withdrawal lowered or heightened appetite, sleeping difficulties, pessimistic or negative thoughts and lowered self-esteem (Megna & Simionescu,2006)psychotic symptoms as such delusions or hallucinations may occur in severely depressed clients. The results gleaned from the study done on 30 depressed young women with the age range of 20-25 years afflicted with depression showed that a combination of pleasant and exuberating practices in proportion to patients and medication therapy (re-absorption inhibitors of serotonin (5 HT) and re-absorption inhibitors of Dopamine (5HT) can be very beneficial to the treatment and control of depression disease. So the test group tended from severe depression to mild depression and the control group tended from severe depression to moderate (mild) depression. Although, medication therapy has some moderate effects of treatment process, it cannot be successful in the treatment and control of depression.

Introduction

Depression is a state that affects a person's mind, emotions, and body. Depression can create a dysphoric mood, lethargy, profound sadness, low self-esteem, and/or anxiety, as well as thoughts of hopelessness, helplessness, and, in a significant number of cases, suicidal ideation. Depression usually includes anhedonia and anergia (lack of pleasure and lack of energy), and may be irritable or agitated, meaning a dysphoric mood is present without lethargy

According to the DSM-IV-TR (APA, 2000a), a major depressive episode is diagnosed if five out of the following nine symptoms are present for at least two weeks:

1. Depressed mood
2. Diminished interest or pleasure in activities
3. Weight loss or gain
4. Sleep difficulties (insomnia or hypersomnia)
5. Psychomotor agitation or slowing down
6. Loss of energy
7. Feelings of worthlessness or guilt
8. Poor concentration and difficulty thinking and
9. Recurrent thoughts of death or self-harm.

Core symptoms that are necessary for the diagnosis are depressed mood and loss of interest. A major depressive disorder can be diagnosed as either a single episode (first major depressive episode) or recurrent (if one or several major depressive episodes have been experienced previously) and as mild, moderate or severe.

Further mood disorder subtypes such as dysthymic disorder, bipolar or cyclothymic disorder, can be differentiated from a major depressive disorder by the severity of symptoms, patterns of recurrence, and the presence or absence of manic or hypomanic episodes. Counsellors and psychotherapists could also consider whether the depression is due to a medical condition, substance abuse or a specific stressor as in adjustment disorder. It would be useful to consider whether or not other psychiatric conditions are also present, such as anxiety.

Prevalence

Depression is a common mental disorder and one of the leading causes of disability worldwide (WHO, 2008). Lifetime prevalence rates of 16% and 12-month prevalence rates of 7% have been reported for adults (Kessler et al., 2003). Data from the Australian Bureau of Statistics have shown that in the prior 12 months, about 6% of the adult Australian population had one or more depressive disorders (Andrews, Henderson, & Hall, 2001; Henderson, Andrews, & Hall, 2000). Women have higher prevalence rates (7.4%) than men (4.2%) (Henderson, Andrews, & Hall, 2000). A study of depression in Australian adolescents has found a prevalence rate of 14%, with significantly higher rates of depression in girls than boys (18.8% versus 9.3%) (Boyd, Kostanski, Gullone, Ollendick, & Shek, 2000). Women are more likely to develop a major depressive disorder. These gender differences seem to emerge in adolescence and persist throughout adulthood (Pettit & Joiner, 2006).

Therapy for Depression

In many cases depression can be a normal response to human experience and survival. Rather than medicating the depression away as a permanent solution, a therapist approaches a person's depression with intense curiosity in an effort to help the person to understand and heal the source of the depression.

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Through the process of focusing internally a person can understand, unravel, and transform their depression.

Psychodynamic approaches often view depression as a defense mechanism, a form of coping or self-protection which relies on "giving up" or "shutting down" to avoid greater emotional risk or pain (see case example: Tommy). And there are other psychological and emotional reasons for depression. Whatever the cause, depression can be improved, if not resolved completely, with therapy. Indeed, research shows that some people may be more predisposed than others to develop depression in response to life events. The familial inheritance identified in depression is both genetic and learned. Whether one is predisposed to depression or not, there is nonetheless a great benefit in addressing depression with therapy.

Depression and Different Stages of Life

Depression should not be confused with normal grief in the aftermath of a major loss, although extended grief may lead to true depression. Depression that is mild and chronic, with fewer symptoms, is known as dysthymia. Depression may present differently based on age or cultural factors. Adolescents tend to show an irritable and agitated depression; older adults may or may not be irritable; certain cultural groups may mask their feeling to varying degrees; women are known to be more likely to admit to depression than men. Depression is one of the most common reasons people seek therapy.

Depression's Effect on the Body

Those experiencing depression may have great difficulty mustering the energy necessary for even the most basic tasks, such as getting out bed, preparing food, or bathing. Depression often includes intense, unrelievable fatigue. Depression may be somaticized, leading to complaints about back pain, muscle aches, nausea, and headaches. Depression may lead to sudden tearfulness without an apparent trigger.

Depressive Thoughts

Depression always includes negative thoughts, sometimes with great severity. Individuals who are depressed may perseverate on thoughts like “I’m no good,” “no one cares about me, “life is pointless,” or “I’ll never feel better.” People with depression may have great guilt or shame, sometimes with an identifiable etiology, sometimes not. Worries are frequently present. In the most severe cases, thinking may be minimal, and the person with depression may border on a comatose state. Suicidal ideation is common.

Feelings of Depression

Depression involves the emotions of sadness and grief, and often anger, fear, shame, and other negative emotions. Affect may be strong, with tearfulness, tension, and possibly anger may be present, or affect may be restricted and in severe cases, flat.

Relationships and Depression

Depression usually interferes with a person’s ability to communicate, express emotion, and to experience emotional and sexual intimacy in relationships. A person who is depressed may be unable to receive comfort from others, believing they do not deserve it or it is insincere. Their lethargy, irritability, or anhedonia may make giving love near impossible. Depressed people often isolate; at the other end of the spectrum they may be overly dependent, attached, or needy. Depression may have passive-aggressive elements that disrupt relationships. Depressed people are often uninterested in normally pleasant social activities, and may be unable to work due to lethargy or fearfulness.

Correlated Psychological Issues

Depression may co-occur with any other mental disorder, and is commonly linked with anxiety. Depression may alternative with manic or hypomanic states in Bipolar disorder or schizoaffective disorder. Depression is often linked to a lack of social support, recent loss, financial stress, and familial depression. Suicide risk is always a concern and must be assessed frequently. Depression must be distinguished from appropriate, short-term grief in the face of loss. Depression can be a major symptom of post-traumatic stress. Depression is also associated with substance abuse, especially with alcohol and other central nervous system depressants. People may self-medicate with such substances to manage depression, making their symptoms worse in the long term.

Medication for Depression

The most popular medical treatment of depression is medication. Several classes of medications have been developed to improve mood. All have a good chance of significant side-effects, in some cases including insomnia and sexual problems. For severe depression, medications can be helpful in stabilizing a person, helping one to get out of bed in the morning, and making talk therapy more effective. Medication can be a lifesaver, for those who have been considering suicide. However useful these medications may be at symptom reduction, they fail to address the emotional and psychological causes of depression, which often underlie the formation and maintenance of anxiety.

College Male Depressed Over Break-Up - Case Example

Tommy, a 21 year-old college student was referred to the university counseling center by his roommate who noticed Tommy was sleeping most of the day, missing class, and skipping meals. Tommy goes to his first appointment reluctantly, but because Tommy recognizes that he hasn't been the same lately, he agrees to keep meeting with his therapist. In therapy Tommy recognizes that his depression began immediately following the break up with his college sweetheart, Lynn, because Lynn was having feelings for another man. In future session, Tommy identifies feelings of grief, betrayal, and deeper down, hidden feelings of inadequacy. Tommy has a breakthrough insight when he discovers that his depression has been helping him avoid these painful feelings. The recognition itself helps the depression begin to loosen its grip. Tommy continues therapy for about a dozen sessions in which he identifies and cares for parts of himself that have felt inadequate since childhood. This increases Tommy's confidence and self-esteem and causes his depression to lift entirely.

Cognitive therapy

There is considerable empirical support for the use of cognitive therapy in the treatment of mild to moderately severe acute major depression. More recent research has focused on the utility of this approach in severe or chronic depressive disorders, in relapse prevention and also on the potential benefits of combining cognitive therapy with medication. This paper attempts to clarify the empirical data on these important issues in order to identify further the role of cognitive therapy in day-to-day clinical practice. It also provides an overview of findings regarding predictors of response to cognitive therapy and the possible mediators of its effects.

The American Psychological Association Task Force[1] published list of empirically validated treatments reports that cognitive therapy (CT) for depression meets all the criteria for designation as a ‘well-established psychological treatment’. Nevertheless, there are still a significant number of unanswered questions regarding the appropriate place of CT in the treatment of depressive disorders. This paper will assess the role of CT through a review of research data published in the last decade. It takes as its starting point the large scale National Institute of Mental Health (NIMH) randomized controlled trial of the

treatment of depression[2]. This study represents an important landmark in depression research that influenced thinking about CT, shaping both the research agenda and advice given in clinical guidelines on the treatment of depression[3],[4]. However, before embarking on the review of subsequent outcome studies, it is useful to recap briefly the basic premises of the cognitive theory and therapy of depression.

Cognitive therapy is a collaborative 'hypothesis-testing' approach that uses guided discovery to identify and re-evaluate distorted cognitions and dysfunctional beliefs. However, the common misconception that CT simply uses a fixed set of behavioural (*e.g.* activity scheduling) and cognitive (*e.g.* challenging automatic thoughts) techniques is unfortunate. The therapy is not simply technique driven. The interventions are selected on the basis of a cognitive conceptualization that uniquely identifies the likely core negative beliefs of that individual and explains the onset and maintenance of their depression. If the patient shows a low level of functioning, behavioural techniques may be used to improve activity levels and improve mood, but the goal is still to identify and modify negative cognitions and maladaptive underlying beliefs. Verbal interventions are initially employed to re-evaluate negative cognitions. Between session experiments, frequently focused on inter-personal functioning, are used to re-evaluate ideas. Later, when the patient has developed his or her cognitive and behavioural skills, these interventions are used to try to modify underlying dysfunctional beliefs. This is critical to the process as the expressed goal of CT is to reduce vulnerability to future depressive relapse

The dramatic success of antidepressant drug therapy for severe major depression has made many scientists question if depression has a strong biological, rather than psychological, basis.

Thus many are questioning whether genetics or stress plays the major role in causing major depression. Recent research has shown that both play a major role in major depression. [9]

Surprisingly, stress has been shown to play a major role in the patient's first two episodes of major depression, but not in later episodes. [10]

So what causes major depression?

- Stress appears to play the most important role for the first two episodes of a patient's depression.
- Genetics and temperament appear to play the most important role for later episodes of a patient's depression.

It appears that major depression often requires stress to "get the ball rolling", but after a few episodes, the illness develops its own momentum and no longer needs stress to "keep rolling". This is a familiar pattern seen in many medical illnesses.

Thus, the treatment of major depression must address the major contribution that stress, genetics and temperament play in this disorder. Unfortunately, most current therapies lack this well-rounded approach.

Psychosocial Therapies

Interpersonal Therapy

The National Institute of Mental Health studied interpersonal therapy as one of the most promising types of psychotherapy. Interpersonal therapy (IPT) is a short-term psychotherapy, normally consisting of 12 to 16 weekly sessions. It was developed specifically for the treatment of major depression, and focuses on correcting current social dysfunction. Unlike psychoanalytic psychotherapy, it does not address unconscious phenomena, such as defense mechanisms or internal conflicts. Instead, interpersonal therapy focuses primarily on the "here-and-now" factors that directly interfere with social relationships. [11]

Cognitive Behavioral Therapy

The National Institute of Mental Health studied cognitive behavioral therapy as the other most promising type of psychotherapy. The cognitive behavioral theory of depression states that the patient's excessive self-rejection and self-criticism causes major depression. This therapy seeks to correct these negative thoughts or dysfunctional attitudes in order to overcome the patient's pessimism and hopelessness. Homework assignments are given to break through the depressed patient's vicious cycle of increased negative thinking leading to increased social isolation which further increases the negative thinking.

A recent review of the scientific literature concluded that cognitive behavioral therapy for depression was promising, but not yet adequately tested. [12]

Recent research suggests that, for moderately to severely depressed patients, pharmacotherapy is superior to cognitive behavioral therapy (at 8 and 12 weeks). [13]

Critics of pharmacotherapy have argued that antidepressant medication only removes the symptoms of depression, but doesn't treat the patient's underlying dysfunctional attitudes.

Critics of cognitive behavioral therapy have argued that the depressed patient's pessimistic, negative thoughts are a result of their major depression, not its cause. Recent research has shown that pharmacotherapy of major depression removes these negative dysfunctional attitudes. [14]

Psychoanalytically Oriented Therapy

The psychoanalytic approach to treating major depression, unlike other psychotherapies, focuses on hypothesized unconscious phenomena, such as defense mechanisms or internal conflicts. This approach to psychotherapy analyzes the historical reasons why the patient has "turned anger inwards against the self" in becoming depressed. This focus on the patient's past is in direct contrast to the "here-and-now" focus of interpersonal therapy and cognitive behavioral therapy.

Psychoanalytic psychotherapy for major depression usually continues with one or more weekly visits for several years. Hence this form of psychotherapy is the most time-intensive and expensive of all the psychotherapies.

There is a surprising lack of any scientific research done on the effectiveness of psychoanalytic psychotherapy for major depression. A modified form of this technique, short-term psychodynamic psychotherapy, has yet to be scientifically proven effective. [15]

Family Therapy

Family therapy is not generally viewed as a primary therapy for the treatment of depression, but it is indicated for cases in which (1) the depression appears to be seriously jeopardizing the patient's marriage and family functioning or (2) a patient's depression appears to be promoted and maintained by marital and family interaction patterns. Family therapy examines the role of the depressed member in the overall psychological well-being of the whole family; it also examines the role of the entire family in the maintenance of the depression.

Patients with mood disorders have a very high rate of divorce, and approximately 50 percent of spouses report they would not have married the patient or had children had they known that the patient was going to have a mood disorder. Family therapy, therefore, can be a crucial and effective modality in the treatment of mood disorders. [16]

Medical Therapies

Major depression is as crippling as chronic heart disease, yet many severely ill depressed patients receive little or no

antidepressant therapy. This needless suffering is tragic in this age of newer, highly effective, antidepressant medications. [17]

Hospitalization

The first and most critical decision the therapist must make is whether to hospitalize a patient with major depression, or to attempt outpatient treatment.

Clear indications for hospitalization are: (1) risk of suicide or homicide, (2) grossly reduced ability to care for food, shelter, and clothing, and (3) the need for medical diagnostic procedures.

A patient with mild to moderate depression may be safely treated in the office if the therapist evaluates the patient frequently. The patient's support system should be strengthened and involved in treatment whenever possible.

Antidepressant Therapy

Antidepressant therapy for major depression can dramatically reduce suicide rates and hospitalization rates. [18]

Unfortunately, very few suicide victims receive antidepressants in adequate doses, and - even worse - most receive no treatment for depression whatsoever. [19] [20]

Most patients don't stay on their antidepressant medication long enough for it to be effective. A recent study found that only 25% of patients started on antidepressants by their family physician stayed on it longer than one month. [21]

General Guidelines For Prescribing Antidepressant Drugs (For Physicians)

- Prescribe the newer, nontricyclic antidepressants whenever possible to minimize side-effects and the risk of death from overdose (since tricyclics have more side-effects and a greater risk of cardiotoxicity). [22] [23]
- If a patient is at high risk for suicide, keep their medications locked up and dispensed daily by another responsible person (i.e., family member or friend).
- Tell the patient to always feel free to bring along a friend or relative to any discussion or examination.
- Inform the patient and family of the risks and benefits of antidepressant therapy. Emphasize that antidepressant therapy usually takes 2-4 weeks before any significant improvement appears (and 2-6 months before maximal improvement appears).
- Stress that antidepressant medications are nonaddictive.
- Give the patient printed information to take home explaining depression and the side-effects of antidepressant medication. Reassure the patient that another antidepressant can be tried should the first have unacceptable side-effects.
- Inform the patient that the first symptoms to improve on antidepressant medication are the more physical signs of depression (e.g., disturbed sleep, appetite, agitation, and fatigue). The more psychological signs of depression usually take a few weeks longer to improve (e.g., poor concentration, apathy, sadness, hopelessness, low self-esteem, and suicidal ideation).
- **Emphasize hope:** the use of antidepressant medication approximately doubles the chance that a depressed patient will recover within 2-4 months. Even without therapy, the majority of patients with major depression recover within 6-12 months.
- Point out that antidepressants aren't "happy pills". Antidepressants have relatively little or no effect as general euphoriants or stimulants in most mentally healthy persons. They only work in depressed individuals.
- Remember that most antidepressant treatment failures are due to the use of too low a dosage for too short a time. Unless adverse effects prevent it, the dosage of an antidepressant should be raised to the maximum recommended levels and maintained at those levels for at least 4-6 weeks before a drug trial is considered unsuccessful. Alternatively, if a patient is improving clinically on a low dosage of the drug, then the dosage should not be raised unless clinical improvement stops before maximal benefit is obtained.
- Stress often plays a major role in depression. Thus, it is essential that major stresses be minimized in order to maximize the benefit from the antidepressant therapy.
- Emphasize that antidepressant treatment should be maintained for at least six months or the length of a previous episode, whichever is greater. At the termination of antidepressant therapy, the medication should be gradually phased out over weeks or months.
  - However, in the middle of antidepressant therapy, one SSRI antidepressant (like fluoxetine or paroxetine) can be abruptly stopped, and another SSRI antidepressant can be gradually started after one or two days of no antidepressant. In this way, the time a severely depressed patient is off medication can be minimized during a switch in SSRI antidepressants.
  - Research is now showing that the majority of patients with major depression suffer from repeat episodes of this crippling disorder. [24]
  - Given that at least 10% of patients suffer from years of major depression, many psychiatrists now suggest that these patients should be placed on long-term antidepressant therapy. [25]

Strategy For Initial Antidepressant Therapy (For Physicians)

- **Indications:** 70% of moderately to severely depressed patients respond to antidepressant therapy. [26]
- **Contraindications:** Don't use in patients with known hypersensitivity to the drug; don't use in combination with MAOI antidepressants.
  - SSRI antidepressants (e.g., fluoxetine [Prozac], paroxetine [Paxil], sertraline [Zoloft], fluvoxamine [Luvox]) must never be combined with a MAOI antidepressant (e.g., phenelzine [Nardil], tranylcypromine [Parnate]). At least 14 days should elapse between discontinuation of an MAOI antidepressant and initiation of treatment with fluoxetine or paroxetine. At least 5 weeks for fluoxetine (but only 2 weeks for paroxetine) should elapse between discontinuation of this drug and initiation of therapy with an MAOI antidepressant.
- **Precautions:** Suicidally depressed patients often overdose with their antidepressant (hence the rationale for initially prescribing fluoxetine [Prozac] or paroxetine [Paxil]). Four to 11% of bipolar patients develop mania or hypomania on antidepressant therapy. [27]
- **First Choice Antidepressant:** The SSRI antidepressants, fluoxetine (Prozac), paroxetine (Paxil), fluvoxamine (Luvox), or sertraline (Zoloft), are excellent choices as the patient's first antidepressant because of their low incidence of side-effects (especially weight gain) and their low lethality if taken in an overdose. All SSRI antidepressants are equally effective. [28] [29] [30]
- **Anxiety And Depression:** Many patients with major depression also suffer from intense anxiety.
  - Fluvoxamine (Luvox) is as effective as lorazepam (Ativan) [44] in reducing anxiety in mixed anxiety-depression. Fluvoxamine usually is given with food at bedtime.
  - Both fluoxetine (Prozac) and paroxetine (Paxil) tend to be stimulating; hence patients with mixed anxiety-depression can often dramatically benefit from the addition of clonazepam (Klonopin, Rivotril) to the fluoxetine (Prozac) or paroxetine (Paxil) therapy [31].

Pleasant Events	Exp.G	Con.G	F week	Pleasant Events	Exp.G	Con.G	F.week
• Relaxing	16	-	3	• • writing diary entries or letters	21	-	3
• breathing deeply	12	-	4	• • cleaning	25	-	4
• • jogging	15	-	1	• • taking children places	19	-	2
• • walking	14	-	4	• • dancing	13	-	1
• • laughing	13	-	6	• • complimenting self for something you do well	19	-	3
• • thinking about positive memories	17	-	5	• • meditating	17	-	6
• • listening to others	19	-	2	• • solving riddles mentally	5	-	15
• • reading	12	-	3	• • seeing or showing pictures	24	-	12
• • participating in hobbies	21	-	1	• • doing crossword puzzles	16	-	6
• • planning a day's activities	24	-	6	• • dressing up and looking nice	19	-	5
• • meeting new people	16	-	3	• • reflecting on improvements	18	-	4
• • remembering beautiful scenery	17	-	2	• • thinking about good qualities	19	-	3
• • saving money	13	-	4	• • debating	13	-	2
• • practicing yoga	19	-	2	• • observing an aquarium	22	-	4
• • repairing things around the house	14	-	3	• • doing something new	24	-	3
• • working on bicycle or car	16	-	1	• • solving puzzles	18	-	2
• • remembering the words and deeds of loving people	19	-	6	• • working	16	-	1
• • having quiet evening	15	-	5	• • discussing books	31	-	3
• • taking care of plants	13	-	3	• • gardening		-	2
• • swimming	18	-	2	• • watching children play	14	-	1
• • doodling	10	-	1	• • listening to uplifting music		-	3
• • exercising	19	-	3	• • making lists of tasks	14	-	7
• • collecting items	16	-	4	• • completing a task		-	3
• • playing sports	17	-	2	• • teaching	18	-	6
• • having discussions with friends	13	-	4	• • thinking about pleasant events	16	-	5
• • having family get-togethers	21	-	5	• • playing with animals		-	6
• • singing	19	-	3	• • sleeping	23	-	2
• • studying	22	-	2	• • playing musical instruments		-	5
• • doing homework	24	-	4	• • making a gift for someone	36	-	4
• • practicing religion	21	-	5	• writing		-	3
• • painting	18	-	3		18	-	1
• • doing something spontaneously	16	-	2		12	-	1
•	14	-	4			-	3
	13	-	6		15	-	6
	18	-	2			-	4
	19	-	4		16	-	3
	19	-	3			-	5
	25	-	5		19	-	2
	25	-	3			-	3
	16	-	2		18	-	2
	18	-	4		22	-	5
	24	-	1		18	-	6
	12	-	2			-	9
	14	-	4		13	-	6
	19	-	6		62	-	
	17	-	5		55	-	8
	13	-	3			-	
	21	-			35	-	15
	22	-	2			-	
	31	-	5		37	-	4
		-	6		15	-	6
	19	-	2		24	-	4
	15	-	3		16	-	7
	13	-	4		18	-	6
	16	-	5			-	3
	12	-	13		55	-	4
		-	1		42	-	6
	17	-	12			-	
		-	5		12	-	
	15	-	3		36	-	4
	15	-	2			-	
	19	-	4			-	6
	20		10				

Table 2. Two-group experimental plan using pre- and post-test in depressed 20-35 years adults

Groups	number	***Medical Therapies***	Pre-test	Pleasant Events	After-test
Experimental group	**15**	*	*	*	*
Control group	**15**	*	*	--	*

Table 3. The statistical analysis of the results for the depressed test group using BDI scale

Pre-test	After-test	D	D^2	t	α
15	10	5	25	10/72	0/01
16	14	2	4		
17	9	8	64		
21	12	9	81		
25	14	11	121		
16	7	9	81		
19	8	9	81		
20	11	9	81		
21	10	11	121		
30	8	12	144		
34	15	19	361		
16	4	12	144		
14	7	7	49		
32	14	18	324		
35	15	20	400		
30	13	17	289		
		$\sum D=178$ $\bar{d}=11/8$	$\sum D^2=2370$		

Table 4. The statistical analysis of the results for the control group of depressed adults using measurement scale BDI

Pre-test	After-test	D	D^2	t	α
19	17	2	4	1/43	0/01
25	19	6	36		
22	19	3	9		
30	30	0	0		
20	25	-5	25		
26	27	-1	1		
27	26	1	1		
29	24	5	25		
22	25	-3	9		
24	23	1	1		
24	23	1	1		
22	21	1	1		
26	24	2	4		
20	19	1	1		
21	17	4	16		
		$\sum D=16$ $\bar{d}=1/06$	$\sum D^2=134$		

Drug Interactions: All the SSRI antidepressants can cause an increase in previously stable plasma levels of other cyclic antidepressants (thus, can increase their toxicity).

- **Initiation:**

○ Start fluoxetine (Prozac) or paroxetine (Paxil) at 10 mg at breakfast, then 3-5 days later increase to 20 mg at breakfast. Experience has shown that starting with 20 mg causes unacceptable side-effects for many patients (and a 21% premature termination of treatment). [26]

○ Start fluvoxamine (Luvox) at 50 mg at bedtime (with food), then increase to 100 mg after 5-7 days.

○ Start sertraline (Zoloft) at 50 mg daily (AM or PM), then increase to 100 mg after 5-7 days.

- **If Not 25% Improved After 2 Weeks:**

○ Increase fluoxetine (Prozac) or paroxetine (Paxil) from 20 mg to 40 mg at breakfast. If still severely or moderately depressed after another 2-4 weeks on 40 mg/day, increase to 60 mg/day. [32]

○ Increase fluvoxamine (Luvox) or sertraline (Zoloft) from 100 mg to 150 mg (as a single dose). If still severely or moderately depressed after another 2-4 weeks on 150 mg/day, increase to 200 mg/day (50 mg at breakfast and 150 mg at bedtime).

- **After 4-6 Weeks On Antidepressant Therapy:**

○ **If Successful:** Continue the SSRI antidepressant for 6 to 12 months. Antidepressant therapy should not be withdrawn before there have been 4 to 5 symptom-free months. Withdrawal from antidepressant therapy should be gradual.

○ **If Unsuccessful:** Discontinue the first SSRI antidepressant gradually (over one week), then substitute another SSRI antidepressant or SNRI antidepressant (venlafaxine [Effexor]). Fluvoxamine (Luvox), sertraline (Zoloft), or venlafaxine (Effexor) often are effective for fluoxetine or paroxetine nonresponders (and visa versa). [33] [34] [35]

- **Pleasant Events Schedule**
- Below is a list of activities that can help keep an individual "mentally healthy."

- Involving oneself in “pleasant events” can help one feel better about themselves as well
- as the world around them.
- When you look over this list of examples, can you identify some as ones you participate
- in?

The exuberating activities were planned as the following table1

In this test which was done experimentally, 30 highly depressed young woman of 20-25 years old who underwent a treatment process for almost 4 months by using anti-depression drugs, Serotonin (5-HT) re-absorption inhibitors, re-absorption inhibitors Fluoxetine (Prozac) with a routine normal dose of 40 mil and re-absorption inhibitor Dopamine (Wellbutrin) with routine normal dose between 200-400 mil.

Using Beek Depression Inventory (BDI) Questionnaire, 21 variables were evaluated including sadness, pessimism, sense of failure, dissatisfaction, punishment, suicidal ideas, crying, irritability, social withdrawal, body image change, self-dislike, guilt, self-accusation, indecisiveness, work difficulty, insomnia, fatigability, loss of appetite, weight loss, preoccupation and loss of libido. The subjects' pre-test score in BDI determined their high and low anxiety rate. Following sorting out, the subjects were randomly categorized into two groups of 15 persons. In the test group, for 14 weeks, pleasant and exuberating practices during the week were designed and implemented in proportion to the interest of the subjects. Meanwhile, a weekly report of such activities was recorded in the personal file of the subjects. However, during these 4 months, the control group composed of 15 subjects (patients) followed their treatment only through medication therapy (Fluoxetine with dose of 10-40 mil and Bupropion with routine normal dose of 200-400 mil), and this group was not provided with independent variable (pleasant and exuberating practice). Then, after 4 months, BDI test was re-done

Considering t=10.72 at the level of α=0.01 and critical t 2.97, the hypothesis 0 (H^0) is rejected. Therefore, it could be concluded that there is a significant relationship between pre-test and post-test scores of the depressed young men test group. So by 99% confidence coefficient, it could be said that using exuberating and pleasant practices during week along with medication therapy are beneficial to the treatment and control of such depressed patients.

Considering t=1.43 and at the level α=0.01 and critical t= 2.97 the hypothesis zero (H^0) is confirmed and it could be concluded that there is not a significant difference between the pre- and post-test scores of the depressed young men in the control group. Therefore, it could be said that by 99% confidence coefficient, medication therapy cannot play effective roles in the treatment and control of depression in young men.

Results

The results gleaned from the study done on 30 depressed young man with the age range of 20-25 years afflicted with depression showed that a combination of pleasant and exuberating practices in proportion to patients and medication therapy (re-absorption inhibitors of serotonin (5 HT) and re-absorption inhibitors of Dopamine (5HT) can be very beneficial to the treatment and control of depression disease. So the test group tended from severe depression to mild depression and the control group tended from severe depression to moderate (mild) depression. Although, medication therapy has some moderate effects of treatment process, it cannot be successful in the treatment and control of depression.

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