Transcript:

Clinical Depression & COVID- Expanding on Mental Health Promotion

Presenter: Dr. Jonathan Kanter
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ANN SCHENSKY: Welcome to our webinar today, Clinical Depression and COVID-19, Expanding on Mental Health Promotion. My name is Ann Schensky, and I will be the moderator for today's webinar. This webinar today is brought to you by the Great Lakes ATTC, the Great Lakes PTTC, and the Great Lakes MHTTC, as well as SAMHSA. Great Lakes ATTC, MHTTC, and PTTC are funded by the Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA.

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We have a few housekeeping details this morning. Today's webinar will be recorded. And the recording and the slides will be available on the Great Lakes Current YouTube channel, in addition to the Great Lakes MHTTC and PTTC Products pages on our websites. We will be sending you a link after the webinar for a short survey. We would really appreciate it if you would take a few minutes and complete it.

Just a couple more things, if you're having technical difficulties during the webinar, please private message Kristina Spannbauer or Stephanie Behlman in the chat section. And they will be happy to assist you. If you have questions for the speaker related to the presentations, please put those questions in the Q&A section. If you would like to find out more about what the Great Lakes ATTC, MHTTC, and PTTC are currently doing, please visit our social media pages, as well as our website.

Our speaker today is Dr. Jonathan Kanter. Dr. Kanter is the director of the University of Washington's Center for Science M Social Connection. Over the course of his career, Dr. Kanter has investigated psychosocial interventions for depression, including how to disseminate culturally appropriate, easy to train, evidence-based approaches, with an emphasis on evidence-based treatments, such as behavioral activation for groups who lack resources and access to care.

More recently, the center has produced research on how to improve relationships and social connectedness on the relational process-- the processes that predict relational well-being and quality of life. Dr. Kanter has published over 100 scientific papers and nine books on these topics. And his

work has been funded by NIH, SAMHSA, state governmental organizations, foundations, and private donors.

He is regularly invited to give talks and workshops nationally and internationally. When the COVID-19 crisis hit Seattle, the center pivoted its resources to understand and mitigate the relational and mental health consequences of the crisis, to assist with public health efforts, and to inform the public dialogue with scientifically informed advice. Good morning and welcome, Dr. Kanter.

JONATHAN KANTER: Hi, can you hear me, Ann?

ANN SCHENSKY: We certainly can. Thank you.

JONATHAN KANTER: OK, great, and I don't know if people can see me, but I'm sitting here in my home in Seattle, Washington. And my family is just waking up in the rooms outside. But they'll be quiet, so that shouldn't be a problem.

I'm really glad to be invited to give this presentation. Although I've been here in Seattle for seven years now, previously I spent 10 years living in Milwaukee, Wisconsin. So I'm very familiar with the Great Lakes area. In fact, the very last trip I went on before social distancing hit and trips were no longer possible, was to Minneapolis, and then another one recently to Rochester. So it's good to be connected with all of you, and I hope this presentation is useful.

As Ann said, my background is really in three broad areas. Number one, depression and depression treatment, with a particular focus on making sure depression treatment is tailored and accessible for minority groups. Number two, social connection and relationships and how to improve people's relationships. And number three, racism and how to get people who are different to get along and have good relationships.

And so this pandemic has been a moment in which all three of my areas of expertise have come together. And honestly, I've never been this busy in my life. And it's a strange thing to have my career go in this direction due to a global pandemic, but it is what it is.

Nonetheless, I'm glad to be here and will lead you through this talk on depression. And this is essentially going to be the outline of the talk. I'm going to spend a few minutes just on a basic primer on depression, and some of the major risk factors for depression, and how they all seem to align lot right now with respect to the COVID crisis. I think there are a few myths about depression out there that are important to at least touch on and offer some alternatives to. Because I think how we talk about depression right now actually matters a lot with respect to our ability to access people and connect with people and help as much as possible.

Number two, we'll talk about some data with respect to what's happening right now. I predicted in an article a couple months ago that we would be facing an epidemic of depression on the heels of the current crisis. And I'm not often right about my predictions.

In fact, most of my predictions about the COVID crisis have been wrong. But this one, I think, I am right about. And now many people are talking about the data and what to do about this. And I think that's why I've been invited to give this talk.

And then third, we'll talk about looking forward, what are the best practices? What are the things I think you all need to know as you think about your prevention and mental health promotion efforts with respect to depression? So we'll end on that.

And I'll end with a couple of tips that are hopefully helpful, with respect to how to talk to people at an individual level about all this stuff. Anyway, that's the outline. And then hopefully we'll have plenty of time for some questions and discussion afterwards.

So first, basic primer on depression and risk factors-- I'm not sure to what degree of you have particular expertise in depression. Hopefully this will hold your attention for the next few minutes if you're already familiar with some of it. But I want to make sure we're all on the same page to start.

So what causes depression? The data here is actually quite complicated. But if you look at your typical undergraduate psychology, abnormal psychology course, you'll tend to find these kinds of numbers. You'll tend to find numbers that most experts agree on.

The consensus is that depression is heritable. In other words, there's a genetic component to it. But the genetic component tends to be about 40% of the influence. And the environment tends to be about 60% or so of the influence.

Now, as the severity of depression increases, so does the genetic component. So for more severe cases of depression, we'll see a genetic component higher. But for most cases of depression, and as I'll argue, what we, how we need to understand depression right now during the COVID crisis in particular, the environment is, by and large, the largest factor in terms of influence. And I think that's important, to not see depressed people as somehow having genetically inferior or problematic brains here, that this is a response to an environment. Anyway, we'll get back to that.

There is a long list of environmental factors that predict depression that have been identified in the literature over decades and decades. This is just a partial list of some of my favorite ones to talk about And I'm not going to spend time on any of these in particular. You can take a look at the list as we go through.

But I will highlight just one or two of them. The very first one, negative life experiences, well, this is obvious. When something bad happens in our lives, that sets up a risk for depression, whether it's a divorce, which is listed separately down there, in fact. Whether it's loss of a job, whether it's an accident, whenever something bad happens, it's going to increase our risk for depression.

But if you look five or six lines down, what actually predicts depression more strongly than these big negative life events is actually the accumulation of

small daily life stressors. So a couple decades ago, for example, we would talk a lot about the soccer moms, who spent their days just helping out everybody else in the family. And just dealing with all the stress, and the medical appointments, and making lunch for the kids, and driving them to soccer practice, and just stress, stress, stress in all these little ways. That actually predicts depression more than big, negative life events.

So as you're looking at this list, and we'll touch on this in a second, you can see just how many of these events are salient right now, as we're talking about all the changes due to the COVID crisis. And you'll also notice, the last thing I'll point out here is that for at least three of these events, they're specific to women. So rates of depression go up for women compared to men in adolescence.

Before adolescence, rates between men and women are about the same. Once adolescence hits, women are about twice as likely to be diagnosed with depression as men. And that stays through most of adulthood until older adulthood.

Pregnancy and childbirth and marriage is a risk factor for depression for women but not for men. And what we see right now with the COVID crisis is, actually, men are catching up a little bit to women. And we'll talk about that in a few minutes.

When we think about clinical depression, if you look at our diagnostic manuals, there are many different diagnoses. And it's really important to not get too bogged down in all the differences. So MDD stands for major depressive disorder. That's our quintessential diagnosis.

But within major depressive disorder, there are subtypes. There's the melancholic subtype, and then there's the atypical subtype. I'm not going to get into these differences because I'm arguing that it doesn't really matter for our purposes. There's also a catatonic subtype.

There's also dysthymic disorder, which is the symptoms are less severe, but they last for longer than MDD. There's depressive personality disorder. There's minor depressive disorder. There's recurrent brief depressive disorder.

And there are actually many, many more. I just ran out of circles in my PowerPoint slide here, just to make the point. And I think it's really important to understand that it's not as if each of these different diagnoses is like a biologically distinct problem.

There's a lot of overlap. And there's actually a lot of confusion in my field and among psychiatry about how best to carve all this up. And I think it's important not to get bogged down in any of that, and to instead look at what all of these different disorders have in common.

And when we talk about what these disorders have in common, it actually comes really clear. There's a core experience that cuts across all these different diagnoses. And we, as human beings, all know that core experience. It's an experience of feeling sad, of feeling down, of feeling blue. Different labels for it, but I think we all know what that feels like.

And when we talk about clinical depression, in other words, a depressive disorder, versus just a momentary state of feeling depressed or sad or down, what we're really talking about is something that has extended or disregulated what is really a normal adaptive emotional experience. Sadness is biologically, evolutionarily adaptive. We feel that for a reason.

But we don't feel depression for those same reasons. Depression is when something goes wrong with that normal, adaptive, emotional experience. And so understanding how it goes wrong is, I think, the key.

And when we think about all these different diagnoses of depression that are out there to consider for diagnostic purposes, I really think the best way to look at it is that we have this core experience that gets disregulated or extended somehow. And then there is just all sorts of variability from person to person, in the time course of that disregulation, in the severity of this disorder, and in all of the symptoms that are correlated with it. And so there's just lots and lots of variability.

One or two things more I'll say here. And then we'll move on to the more contemporary stuff, which is that, there's an old model called the diathesis-stress model of depression, which is being blocked by some of my-- oh, dear. That was not supposed to happen. My apology, I'll be back to my slides in just a second. Don't do that again.

I think we can look at this combination of genetic influences and environmental stress in terms of what's called a diathesis-stress model. And so the basic idea is that we all don't want our glass to overflow into depression. So how much risk is in our glass is a function of our genetics and our environment.

And that's going to vary from person to person. So some of us have very low genetic predisposition. And we need a lot of environmental stress poured into our glass for it to overflow into depression. Whereas others will have a stronger genetic loading, a stronger genetic predisposition to depression. And they will need less stress poured into their glass to overflow into the depression.

And I think, with that in mind, I think what we're seeing right now with the COVID crisis and everything going on in the world, is so much environmental stress being poured into so many glasses. That many people are going to be experiencing depression right now, even though their genetic risk is very, very low. So many people are going to be experiencing depression that haven't before and that wouldn't necessarily in normative times because of the overwhelming environmental stress that is being poured into their glasses right now.

So when we think about what's happening right now, I do think COVID-19, and this is sort of a cliche at this point, presents a perfect storm of environmental stressors. I'm going to go through four categories of stressors that are at play right now. And then we'll talk about what to do.

So these are the four categories of stressors that I believe are at play right now-- stress, loss, social stressors, and financial stressors. And if you're

interested in more of the background, I wrote about this in a piece in The Conversation. And the link to that is down there at the bottom, and we can provide you these slides and so forth if you want all these things afterwards.

So first, acute and chronic stress-- I think what you need to know about this is that stress, chronic stress leads to depression. It's one of the most consistent findings in biological psychiatry of depression. When our stress response system, the HPA access, or the fight or flight system, or whatever you want to call it. When that stress response system is hyperactive and hyperactive for an extended period of time, it's very likely we're going to get depressed eventually.

Now, in particular, at the individual level, there's several studies that suggest we should be paying attention to when we wake up in the morning and immediately feel stressed right upon awakening. When there's increased cortisol in the morning, that's a particularly bad sign if that's happening day after day after day. We all have elevated cortisol in the morning, but the risk for depression is when it's particularly elevated day after day.

And in general, anxiety disorders and trauma disorders typically precede and predict depression. And so while there's so much talk right now in the world about all of the anxiety and trauma and stress that people are feeling, this is true. And for me, I see that happening now. And I see depression coming on the heels of all of this because we know that when our bodies are feeling this way for a long period of time, depression is a result. And I won't get into the biology of why that happens because that's sort of not of interest today, but this is, unfortunately, the situation.

Number two, personal trauma, loss, and grief-- some of us, not most of us, but some of us because of the COVID crisis, as you all know, are experiencing trauma and loss and grief at a really significant level. Recent statistics suggest, you may have heard these because they've been bandied about social media. But recent statistics put the rates of depression as one in 1,850 Black Americans have died of COVID-19. And that number is going to only increase because the number of Black Americans is staying the same, but the number who are dying is going up.

And then one in about 4,400 white Americans have died of COVID-19. And so these family members who are dealing with trauma and loss and grief are, of course, really struggling right now. And it's not most of us, but it's a lot of us. And it's a lot more than we're used to.

And from the perspective of depression, what's particularly concerning is that these people's grief or grief processes have been completely disrupted and messed up. And we know that when grief becomes complicated, that leads to depression over time. And so I'm particularly worried about people who have experienced these real losses right now and haven't been able to grieve properly, and how depression may be on the heels of this for them.

And of course, there's a lot of talk about frontline health care workers. And the data on trauma and depression in frontline health care workers is really significant. And I'll talk more about that in just a minute.

Social difficulties, the third element here of the four risk factors that I'm reviewing. At the beginning of this crisis a few months ago, myself and others really predicted, because of social distancing, essentially a wave of loneliness that we were worried was going to cascade across society. And we know from lots of research that loneliness is a risk factor for depression. In fact, I have some data I'll show you in a few minutes that it's probably the highest risk factor for depression.

And what's interesting is that we didn't actually see that manifest. We didn't see a wave of loneliness wash across our society. And I think many experts like myself were wrong because we didn't predict this feeling of solidarity that many of us had as we were socially distancing. As we were isolating, there was this awareness that we were all in it together.

Loneliness, after all, is a psychological phenomena. It's not just a function of social isolation. And I think that solidarity and the fact that society was doing this together really protected many of us from loneliness.

That said, some of us are experiencing loneliness right now. And those are the people I want to identify and help you help. But it's not a wave of it. What is happening, however, is that month after month of social distancing and being stuck in our homes is increasing all sorts of negative emotions, frustration, boredom, just lack of access to rewarding experiences and social contact. And all that over time is going to drive up depression rates.

Then of course, also the increased amount of family conflict. There's an early study out of China that divorce rates were up in Wuhan right after the coronavirus hit. And we expect similar things like that to happen here. So while loneliness isn't necessarily the huge public health problem that we were predicting, the social distancing and the social isolation still is causing lots of problems that are risk factors for depression with loneliness being one of them.

And finally the biggest problem, of course, is the financial difficulties and the financial strain that's coming down really hard on lots of people right now. Some data from the 2008 recession, the 2008 stock market crash, is really interesting. The result of the 2008 stock market crash is that wealthy people, in response to the crash, of course, experienced large wealth losses.

And many of them demonstrated an increase in antidepressant prescriptions. And so we saw an increase in help-seeking. But for the wealthy, we did not see an increase in depression rates.

And something like that likely is happening now. If you look at data from February to March in 2020 during the COVID crisis, we actually saw a rapid increase in anti-anxiety and antidepressant prescriptions, a 34% increase in anti-anxiety prescriptions, a approximately 20% increase in antidepressant prescriptions. And you might think, oh, that's actually not that high.

But you have to appreciate, for about the last two decades or so, rates of anti-anxiety and antidepressant prescriptions had been on the decline. And then suddenly from the beginning, from the middle of February to the middle of March, everything switched. And now we're seeing an increase.

And 78% of these prescriptions are new prescriptions. In other words, people who had not been seeking antidepressant or anti-anxiety prescriptions before were now asking for prescriptions by the middle of March. And so I guess that's a good thing.

But we expect that there are going to be disparities in who is asking for those. And we expect people who are more resourced, who are more connected to their primary care, who are more educated about depression, who are higher socioeconomic status to be the ones reaching out and getting these prescriptions. And that's where the problems lie.

Unemployment, per se, does not predict depression. Loss of wealth, per se, does not predict depression. What does predict depression is when that loss of wealth, when the unemployment causes considerable strain and stress. That's what predicts depression.

So while wealth loss didn't predict depression in 2008, home foreclosures did. A 62% increase in rates of clinical depression among those who had home foreclosures in the 2008 recession. Material hardship and that kind of financial strain, that's what predicts depression. OR stands for odds ratio. And if you're not familiar with odds ratio, the way to interpret an odds ratio is quite simple.

An odds ratio of 1.47 there for financial strain simply means that those who were experiencing financial strain were one and a half times more likely to experience depression, compared to those who weren't experiencing financial strain. So those who were experiencing financial deprivation in 2008 were 19% more likely to experience depression. And then ceasing to live with your partner in the 2008 recession, because of financial difficulties, you had to move out, big odds ratio, double the risk of depression there.

So these are the kinds of nuances with respect to the financial crisis and unemployment that I think are important to understand. So what is happening right now, let me just take a look at the time here, see how I'm doing. OK, I'm doing OK.

What is happening right now, some data on what's happening live. First of all, I mentioned earlier the data from China. This came out in the Journal of the American Medical Association about a month or two ago, showing that health care workers in China during the initial outbreak in Wuhan had an increase in symptoms of depression of 50% over that time.

And in particular, among the health care workers in China, those who were at most risk for depression were women who had about double the odds compared to men. Those who had intermediate titles, in other words, nurses were more likely to be experiencing depression compared to actual doctors. And then, of course, those who were on the actual front lines, who were in the hospitals, really treating people on a daily basis, had a higher odds of experiencing depression.

So these are the people, the health care workers who we're particularly worried about with respect to depression right now. And I don't really see why there's a reason to suspect that this China data isn't at least broadly generalizable to what's happening here in the United States. I'm not quite sure

what would be that different, but this is data from China and not from the United States.

This, however, is data directly from the United States. You may be familiar with this. If not, I suggest you become familiar with it. This is the data from the CDC and the Census Bureau. It's what they're calling their Household Pulse Survey.

And they've been now surveying people for, I think, over a month. I'm showing you data from the week of May 14 to 19. So I'm apologize. I put these slides together a couple of weeks ago.

But they actually have a couple newer weeks of data in their data visualization dashboard that you can go look at real easily and get the updates. The updates are that, the rates of depression that I'm showing you today have just ticked up just a teeny bit. But what I'm showing you today is still roughly, is still very close to current data.

So first, symptoms of depression in the United States by gender-- 27% of women in the United States in the survey are endorsing symptoms of depression compared to 22% of men. And my take on these numbers is that the numbers for women aren't that much higher than we would typically expect. But the numbers for men are actually higher because, typically, we would expect the difference between men and women to be about two to one.

And now you can see, the men are inching up towards women. So that's not to dismiss the numbers for women because A, they're still higher. And so we're still seeing more depression in women. But men are higher than typical for them right now.

These are data by age from the CDC Household Pulse Survey. And you can see that almost uniformly, the younger you are, and they don't have data on adolescence, just 18 and older. The younger you are, the higher that the symptoms of depression here.

And this is also not what we would typically expect. Typically, we expect the highest levels of depression in the middle age groups, not in the younger groups here. And so something a little different is going on right now, as well.

And present of symptoms of depression by race-- and there's some nuance here that I can't get into all the details on. But I will just try to portray it real quickly. We see the highest rates of depression in Latino population, and then lower rates in Asian, Black, and white, and then higher rates again in people who are classified as other, which is a catch-all category of lots of different people, unfortunately.

One thing to say about the higher rates of Latino symptoms is that we know from research that Latinos in general tend to report higher rates of symptoms but not higher rates of disorder. So hopefully that's not too confusing for people. They tend to express and share their distress, but they're still functioning well, functioning well enough to not slip into a clinical disorder.

So I don't want to diminish the importance of focusing on Latinos right now and their symptoms. But it's important to note that this survey is just

symptoms of depression. It's not how many are diagnosed with a clinical disorder.

And by the way, this is just an aside, but it's, I think, an important aside that I just want to throw at you right now. For Latinos who immigrate to the United States, depressive disorder is predicted by the length of time in the United States. People who immigrate here and have only been here for a short period of time have lower rates of disorder, whereas Latinos who have been here for a generation or more have much higher rates of disorder. In other words, something about being in the United States is depressing. That's another story.

Last, the CDC also has their data broken down by state. And so you can look at your state if you want to. I didn't put all of the states on here. But I will just note, and I don't quite know what to make of it, that Mississippi, according to the CDC data, has by far the highest rates of symptoms of depression. And then you, all of your states aren't on here, but you could go to the website and look up your state if you want to.

One caution about this data I just presented to you, these are symptoms of depression. What they did is they asked people about the two most common symptoms. Are you experiencing depressed mood? And are you experiencing a loss of interest and pleasure in things?

And asking about symptoms of depression predicts clinical depression. But it's not the same as clinical depression because in order for symptoms to translate into disorder, those symptoms need to cause you functional impairment. And they need to last for two weeks, whereas this survey only asked for symptoms for one week.

Not to get, I don't want to get into the weeds on this. But I just wanted to let you know that the numbers I presented you shouldn't be interpreted as rates of clinical depression. Clinical depression rates are probably a little lower than this.

This is actually data that we collected in my lab. This is data from a national sample of about 720 people that we are collecting right now. This is data from last month. And the way to interpret this chart is these bars all indicate the correlation with symptoms of depression.

So if you look all the way down at the bottom, you can see the highest correlation is lonely. And that's a correlation, if you can read the numbers there, of about 0.8, so extremely high correlation. If you're feeling lonely right now, you're very likely to also be feeling depressed. If you're feeling overwhelmed by anxiety right now, you're also very likely to be feeling depressed.

The red bar means this thing I've listed here is a bad thing, and the green bar means it's a good thing. So if you're satisfied with relationships, you're very likely to not be depressed. That is a negative correlation. The more satisfied with relationships you are right now, the less depressed.

And so I won't go through every one of these on the list here, if people can, have a question about one of them, you can note that question and then

perhaps ask it later. But I'm just wanting to point out that the biggest predictors right now in our sample are loneliness, feeling overwhelmed by anxiety, and then relationship factors. How close and connected do you feel to others? Do you feel understood and cared for by others in your life? And are you satisfied with your relationships?

By the way, everything I've listed on this slide is a significant predictor of depression. So all of these things matter. But some of these things are correlated with depression much higher than others.

The last thing I'll say is that, and you may have been exposed to some of this. And if not, this is a good resource for you. The Meadows Mental Health Policy Institute in Texas has done some projections on suicide rates right now that, I thought it was important to share with you, if you haven't been exposed to them before.

And their data scientists have looked at past recessions and essentially identified that for every 1% increase in the unemployment rate, we expect a 1.6% increase in the yearly suicide rate. And so we can now look at what the employment rates are in your state or in your region and do this projection and think about, how much are we having to worry about suicide right now? If we look at that nationally and look at national suicide rates, it means about an additional 775 suicides for every 1% increase in our national unemployment rate.

So I do think the good news is, the numbers have gone down over the last couple of weeks. But a couple weeks ago when I put the slide together, we were all worried about a potential 20% increase in unemployment, which would mean, according to these projections, an additional 18,000 suicides annually in the United States. And so that's pretty depressing and alarming numbers. And again, the good news is it looks like the unemployment rate is not as high as what I have in this slide.

The last thing I'll share, and this is an impossible slide, which is just a teaser if you want to go look at the actual data. This is some data projections from the well-being trust. And they are adding suicide death by drug overdose and death by alcohol altogether, and talking about this phenomenon that has been in the news of deaths of despair. And I'm not going to get into the weeds on this slide. You can look it up if you're interested.

But the bottom line is they've done some pretty sophisticated calculations, taking various contingencies into account. And if you look at the median set of assumptions, kind of like right in the middle, not very low risk assumptions, not very high risk assumptions. If you look at the medium set of assumptions with respect to how bad unemployment's going to be and some other assumptions, they're predicting essentially an additional 65,000 deaths due to depths of despair over the next five or six years. So that's what we're up against right now.

Now, the thing about projections is projections depend on how responsive we are to the problem. So these are projections without an improved response. And we're here to talk about how can we improve our response and make these projections wrong.

So some things I want to say looking forward in best practices-- how we talk about depression matters. The general discussion here is that we shouldn't talk about depression as a character problem. And I'm sure many of you are already aware of this. We don't want to blame people. We say, well, you're weak, or there's just something wrong with you, or you're lazy, or whatever.

The standard alternative to that character talk has been what I'm going to call here "biology talk." In other words, depression is a real disease. It's just like any other physical disease. Maybe you've heard the comparison to diabetes or something like that. Depression is a brain disease, and we have to treat it as a real disease.

That's been the typical way of talking about depression. And I'm here to tell you that there are actually some pitfalls to talking about depression in that way. Research suggests that that biology talk about depression does decrease stigma. It's not the person's fault if it's a real physical disease. It does decrease blame.

But emphasizing the biology of depression also decreases most forms of help seeking, except seeking antidepressant medication. And it also increases punitive behavior from others, and essentially gets people to treat the depressed person like a child who has no control over their behavior. So throughout this talk, I've been emphasizing environmental talk instead of biology talk.

I've been emphasizing all of the environmental factors, the contextual factors that increase risk for depression. And there's research to suggest that when we emphasize these factors and say, this is what causes depression, it also decreases stigma and blame like the biology talk. But it also increases a variety of forms of help seeking.

And most importantly, it also increases the likelihood that people will talk about how they're feeling to others, which biology talk doesn't help with. So I'm really emphasizing this environment talk because I think it can get more people into treatment. And it also fits how many minority groups conceptualize depression, which is important for thinking about depression not just in terms of the mainstream here.

What does science tell us about prevention programs? There are a couple of reviews here that you could get into if you want to get into the weeds. The bottom line is multi-component depression programs do work, but they don't work that well. When you're doing sort of a large scale public health multi-component depression program, the meta analyses suggests you can decrease depression rates by around 11%.

We're not entirely sure the best way to do this. I have to be honest. I can tell you that the more you do, the better. It's not going to be just one thing. It's going to be how many different things can we do to get out there and talk about depression.

Simple behavioral pleasant event scheduling stuff, getting people to do pleasant stuff, according to these meta analyses, is not effective as a depression prevention program. Most effective, according to this research, is

teaching people coping skills. And a lot of people talk about social support groups. Social support groups are effective at preventing depression but only for older adults. So those are some considerations.

As we go forward, I think it's really important to keep in mind the risk factors that I reviewed with you earlier. In other words, you don't actually have to target depression specifically in order to target depression. If we do things to help people manage their stress right now, we are also preventing depression. If we do things to treat and be really responsive to and provide evidence-based treatments for trauma right now, we are also preventing depression.

Anything we can do to help people with financial problems and with financial strain. When I see Congress debating about what to do with stimulus checks and all that money, politics aside, I know as a depression expert that the more we can help people financially right now, the more we can prevent depression. And anything we can do to help people with relationships and with family conflict, we're also helping with depression.

So all of this stuff matters. There is a decent amount of research on something called mindfulness-based cognitive therapy for prevention of depression relapse. And these are essentially eight week courses that teach people to simply slow down, connect with their bodies, learn how to breathe. All of this, of course, is also reducing stress. But it's also increasing our skill at noticing when we're starting to get into patterns of depressive thinking and trying to be more mindful of those patterns.

So these mindfulness courses are really helpful in preventing depression. These are things you probably already know. And I'm just highlighting things because the research suggests they're important. So if you already know it, that's good. Do this stuff. Promoting exercise and healthy lifestyle options are also going to help prevent depression.

Most depression is treated in primary care, as you probably know. So anything we can do to increase people's connection to and coordination with primary care and help primary care doctors manage the burden and the load. And make sure primary care doctors are equipped with good referrals and good sources for depression treatment, is going to really help manage this as a public health crisis. And of course, increasing telehealth, especially because the rates of depression that we're seeing right now may be younger people, people who are in more rural areas.

Telehealth is just, in general, a good idea, even before COVID. And in particular, it can be a good idea now. And it's also helpful because you can reach out to and treat depression without having somebody have to come into a mental health facility or to a private practice office where there's a lot of stigma. So telehealth in general is, I think, a good, a really good and important idea.

As I said before, I'm going to be done in about two or three minutes, and then we'll have questions. So as I said before, there are specific groups that I think we need to be paying attention to. These are sort of obvious, again, but they're important.

Number one, the frontline health care workers, these people are on the front lines every day. They're experiencing trauma. They're experiencing tremendous amounts of stress.

They're also very isolated. And I'm very worried about them in terms of depression. So anything we can do to target and work with and connect with them and help prevent depression is, I think, super important.

Those who have experienced direct loss, as I mentioned before. I think there are things we could do to reach out to people whose family or relatives have died of COVID right now. And try to find some way to work with these groups and see how they're doing over time, I think, is super important.

Of course, those who have been hit harder by the financial crisis, it's not the case that Latinos and Black Americans are experiencing higher rates of depression right now. But they are experiencing higher rates of all sorts of stressors and problems and financial strain and death. And eventually, that's going to hit them.

They in general are used to dealing with stress. People from minority populations have been dealing with stress in ways their whole lives. And so in some ways, they're more prepared for this crisis, but that preparation doesn't mean we should leave them alone. We should recognize that some people are under extreme amounts of stress.

And anything we can do to reach out and work with them with respect to depression prevention is going to be important. And then finally, those living alone, or who have changed living situations, this loneliness thing, again, we're not seeing this massive social wave of loneliness. But those who are lonely are going to be at increased rates for depression.

Group treatment is a really good idea, and it's more scalable than individual treatment. So to the extent people are in treatment settings and are able to provide or get trainings on treatments, I'm going to put in a little plug for one particular treatment that I've been involved in the past called "behavioral activation." It's an evidence-based psychotherapy for depression.

The evidence suggests that it's easier to train and implement than other treatments. And I think that's really important now. We can train nurses in behavioral activation. We can train social workers in behavioral activation. We can train paraprofessionals to engage in behavioral activation treatments.

And so I think this is fairly scalable, and it's just as effective as other treatments. And it's cross culturally acceptable. It tends to work well across cultures. And I could give you that data in a different talk. So just a little plug for that, if we're talking about group treatment, which I think is important. This could be a particularly effective approach.

And finally, my last slide-- to the extent we're going to be talking to people about depression ourselves, I think it's really important how we talk. And it starts with validation and normalizing. The idea here is that how we feel in our bodies makes sense.

If you're feeling a lot, whether it's stress, anxiety, trauma, sadness, despair, hopelessness, depression, our perspective has to be, those feelings make sense. Your body's doing what our bodies are naturally, evolutionarily designed to do. There's nothing wrong with you. You're not sick. You're feeling a lot.

Anything we can do to keep hope alive, and by the way, keeping hope alive doesn't mean telling somebody, you shouldn't feel what you feel. You're going to be fine. Hope with the validation, what you're feeling makes sense, and I believe in you.

I'm never going to give up on you. I believe we can help you get a better life, even if you're feeling despair. There's always hope, and my job is to keep you always in touch with that glimmer of hope.

Flexibility-- there is something about our society that really values and prioritizes this idea of tenacity and hard work and never quit and never give up. And those are good values and good skills. However, to prevent depression, knowing when something isn't working, when it's time to adapt and adjust and come up with new goals and new life pursuits because something is no longer available, is also really important.

So many of us right now are facing losses and changes in jobs. And flexibility and openness to new ideas is really important. I already talked about mindfulness and acceptance. This idea of increasing people's capacity to just feel what we feel in our bodies without these feelings shutting us down.

As I said just a moment ago, we as human beings actually have tremendous capacity to feel a lot. The problem isn't the feelings. The problem is when these feelings lead us into despair and hopelessness and shut us down. It's really important to connect people with their deep-seated values, their goals, their life pursuits, their dreams, even when they're depressed, and try to help people engage in action every day to stay aligned with their values.

The most wisdom I have as a human being, as a clinical psychologist, personally, is to wake up every morning, to try to connect with my body and my feelings, to try to breathe, to recognize that I may be feeling a lot today. And then to ask myself, who do I want to be? What's important to me?

And by the way, personally, what will show up for me when I ask that question is I want to be a good dad to my 15-year-old daughter and a good husband to my wife. And then try to do that over the course of the day. Even in the face of insurmountable odds, even in the face of tremendous problems and stress, can I at the end of the day say, today I engaged in important stuff?

The goal is not necessarily to feel better. The goal is to keep striving. And I think that's actually the best way to treat depression.

Now, I have a little metaphor here. This picture of this bus, the idea of this picture of this bus is that I think one quick little metaphor that I like, which I'll end with, is that you are the bus driver. And the idea is that you can engage in a process of-- my reminders. I should have turned those off. I apologize.

You can engage in a process of identifying what your values are. In other words, which direction do you want to drive this bus? You're the bus driver. Which direction is important to you?

And all of these feelings, the sadness, the stress, the anxiety, all of those self-critical thoughts, you're not going to succeed. You're a failure. Nobody is going to believe in you, or whatever it may be. All of those feelings and thoughts, they're like passengers on your bus. And no matter how loud they yell at you, no matter how much they tell you to take the detour or to go a different direction, you still have the capacity to drive your bus in the direction that you want to go.

I'll stop there. And hopefully there's time for some questions and comments. And so I'll let Ann jump back in and orient us at this point. And should I continue to share my screen, Ann? Or let me know what to do there.

ANN SCHENSKY: You are welcome to continue to share it. This way, people can get your contact information.

JONATHAN KANTER: OK.

ANN SCHENSKY: I really, really appreciate your presentation. It has been phenomenal, and just a lot of really, really good information. We do have some questions that I'm just going to go through.

JONATHAN KANTER: Yeah, and if we can't get to the questions, I'll try to be responsive over email and respond to people afterwards. I guess I talked for a little longer than I hoped to, so.

ANN SCHENSKY: No, fantastic. Our first question is, why are women more prone to depression as compared to men? And what are the major reasons?

JONATHAN KANTER: Oh, I need an hour to answer that question. There are multiple reasons. I think the quick thing I'll say right now is I want to really caution people, again, against biological or even hormonal explanations for those differences, even though some stuff like that is potentially involved. What we see is an increase in rates of depression for women when they hit adolescence.

And we know that when they hit adolescence, all sorts of environmental things change. All sorts of expectations change. And so the social pressures that women face, the environmental pressures that women face, the system that women live in that essentially tells them-- sorry to be a little social justice-y in this moment.

But the system that women live in that essentially tells them, your job is to find a husband. Support the family. Maybe you can have a career, but your first priority should be the family. All of that stuff individually is identified as risk factors for depression.

So we as a society are set up to actually make women depressed. Oh my gosh, that was a very depressing thing to say. I don't have time to get into it in more detail. But that's, I think, unfortunately the best way to look at it.

ANN SCHENSKY: Thank you, I guess.

JONATHAN KANTER: Sorry, yeah.

ANN SCHENSKY: Has there been an increase in the rate of teen suicide due to COVID-19?

JONATHAN KANTER: Don't know the answer to that. I don't think we have seen a large increase in suicide rates in general yet. These are projections. Here in Seattle in Washington state, we did our own statewide projections. And they predicted that the peak of suicides is potentially going to be in November, December of this year. That's when we're going to start to see an increase.

So we haven't seen too many increase suicides yet. We've seen increases to suicide hotlines, but I'm not aware of a real bump in suicides yet. And I'm not aware of how this is playing out among adolescents. I'm sorry.

ANN SCHENSKY: Thanks. What specifically is behavioral activation?

JONATHAN KANTER: The basic idea of behavioral activation is consistent with that very last slide that I put up. And these are actually evidence-based suggestions. The basic idea is we want to identify what your values are, what the things that are meaningful to you are. And this can include pleasant events but isn't just pleasant events.

And then we want to get you moving with your behavior towards these things. In other words, most depression treatment is, we got to get your negative feelings down, so then you can start behaving again. Behavioral activation reverses that. We're going to just get you behaving first--

[PHONE RINGS]

Oh my gosh. We're going to just get you behaving first. And once you start behaving in more positive ways, then your feelings are going to go down. So it's directly trying to activate patients to start engaging in behaviors, even though they're depressed.

ANN SCHENSKY: Great, thank you. Our next question is clinical depression and remission. How do we address it? When people in remission who don't experience depression for a period of time then jump into a depression again, how can we help in this situation? And not to mention, the clinician's own frustration.

JONATHAN KANTER: Yeah, it's tough. Depression is a bear. And remission rates are high. Once you've had your first episode of depression, then you're more likely to have your second and your third episode of depression. So it's demoralizing, of course, for the patient and for the provider.

To the extent that we can teach people coping skills, and in particular, I mentioned before, this mindfulness-based cognitive therapy approach. Those are pretty much our best evidence-based suggestions for helping somebody who has been depressed stay away from a second episode of depression. But when you're working with somebody who has recurrent depression, whose depression keeps returning and returning, then unfortunately we're in a world where psychiatry is going to have to take a larger role.

Medications are going to have to take a larger role. And some of these more invasive options are going to have to come into play, which is unfortunate, because they can really adjust somebody's life trajectory. But that's what's needed. This is tough stuff at that level for recurrent depression.

I think the way we treat it psychologically, behaviorally, isn't really that different than the kinds of stuff I suggested today. So it's not like it's a different approach. It's more that we just have a lot of humility that it's tough. And we can't help everybody as much as we want. There's much we don't know, unfortunately. Oh, I feel like all my answers so far are rather depressing answers, but that's what I've got for you.

ANN SCHENSKY: OK, well, they're the reality. I have a couple more questions before we run out of time. But on the topic of depression between men and women, I believe men experience just as much depression. Our expression of depression is different. Men don't verbalize it as easy as women. What are your thoughts on this?

JONATHAN KANTER: I think the data would suggest that it's a both, not a either/or answer. In other words, women do experience more rates of depression objectively. And women are better at expressing their feelings. So we're not going to account for the whole difference between men and women by awareness that men aren't good at expressing their feelings. So the gender difference will still remain, even if we get all men talking about their feelings.

ANN SCHENSKY: What issues come up with getting people off of antidepressants?

JONATHAN KANTER: There's been a good amount of research on that. We know that if you can get somebody in a course of psychotherapy, whether it's cognitive therapy or behavioral activation or any of, there's multiple evidence-based treatments for depression. A course of psychotherapy can actually really help somebody prevent relapse when they get off their antidepressants.

If they're on antidepressants and then they're suddenly removed from the antidepressants, then rates of relapse will shoot way up. But there are things we can do to prevent and mitigate that. And again, I think it has to do with coping skills and what psychotherapy can teach people.

The idea is that if we feed a person a fish, we feed them for a day. But if we teach them how to fish, then they can feed themselves for a lifetime. And I think that's the difference between just of course of antidepressants and antidepressants plus psychotherapy. A combination of antidepressants plus psychotherapy tends to work better than either modality alone, and also tends to be the best for preventing relapse.

ANN SCHENSKY: Excellent, I think we have time for one more question. But I want to just remind everyone that we will send the remaining questions to Dr. Kanter so that he can answer them. And all of this information will be provided on our websites when we post the webinar and the slides. So one question is, can you talk about how nutritional deficiencies can play a role in depression, such as a gut bacteria?

JONATHAN KANTER: Yeah, that's not, that question, I have to admit, isn't the best fit for me. I do know there are experts who know more about that than I do. I haven't paid too much attention to that particular literature. But I do know it's out there and that there is interest in exploring those things. And there's some evidence to support it.

ANN SCHENSKY: OK, we have reached the top of the hour. So again, we will make sure that all of the questions that were submitted are forwarded and answered. I just want to thank you again, Dr. Kanter, for your time and your expertise.

This was an amazing webinar. And I would like to thank everyone for spending time with us. So thank you, and have a good afternoon.

JONATHAN KANTER: Thanks, everyone, hope this was helpful.