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Second Annual Conference on Depression, September 23, 2007
Mount Zion Apostolic Tabernacle Church, 2101 Dempster Street
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DEPRESSION IN AFRICAN-AMERICAN WOMEN

Good afternoon. I am delighted to be with you this afternoon to discuss a topic that is important to me. I have always been interested in and fascinated with human behavior and mental health in particular. I love to find out what motivates individuals to make their decisions. I don't possess this interest in any kind of voyeuristic way but I work to understand the inner workings of clients I work with and work to put myself in their shoes to understand their perspective. This process is two-fold and is a reciprocal process as I am constantly engaged in self reflection, introspection. I find that when I have a greater sense of myself I can then be more available and present to those I serve. I work to incorporate spirituality into the practice of psychotherapy. The practice of developing a therapeutic alliance with a client is greatly enriched when one is invited to bring their faith tradition and their experience of spirituality into the session.

I am always thrilled to be a part of any forum in which people can access information to improve their lives and become their best selves. In the time that we have together, I am going to: define depression; list the symptoms of depression; talk about the various forms of depression; briefly list some of the co-morbid or co-existing conditions that may accompany depression; discuss treatment options for depression and close with a comment about the spirituality of depression.

Within the AA community, there is a stigma about depression and mental illness in general. Culturally AA have been taught not to trust outsiders or professionals and to “keep this in our house”, “This is our business”. Many of you may be able to relate to having an aunt or an uncle who was not all there. You know, “Is crazy Uncle Willie coming to the reunion?” As a result, help or treatment is not sought and people remain in a state of suffering, unnecessarily. In the past, African Americans have not had the opportunity to hear depression described as the medical illness that it is. Being mentally ill was called and in some instances is still referred to as “being crazy” or “touched”. In the early 70’s it was in vogue or fashionable to have a therapist or a shrink. It was a symbol of financial wealth whereas in the AA community, it was thought to be a luxury or a waste as some did not possess the income necessary to see a mental health professional. With the continued increase of affluent AA, there is also a greater understanding and acceptance of the validity of depression and mental illness.

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A person is diagnosed as having clinical depression if they also demonstrate four of the following symptoms.

Symptoms:

1. Depressed or irritable mood throughout the day (often everyday)
2. Dramatic changes in sleeping patterns. For example, sleep a great deal more than usual or decreased sleep.
3. A dramatic gain/loss in weight; a change by 5% or more in weight over a period of four weeks. Ex. If you are a 180 lb woman and you either gain or lose 9 lbs over a one-month period.
4. Unusual, increased, agitated or decreased physical activity.
5. Daily fatigue or lack of energy
6. Daily feelings of worthlessness or guilt
7. Inability to concentrate or make decisions
8. Recurring thoughts of death or suicidal thoughts. (APA, 1994)

Before I move on to what depression looks like in AA women, I want to briefly talk about the various types of depression. This is important because the word depression is tossed around loosely and there are many different forms of depression.

Types of Depression

<u>Dysthymia</u>-What distinguishes this type of depression from clinical depression is the duration and the severity of symptoms. Dysthymia is longer lasting in duration and milder in its severity. These individuals always seem to have some symptoms of depression. This person can and does function but has a general down mood.
*Insert example of Mary Tyler Moore TV show where Mary was down and sought comfort from Ted, the office buffoon.

<u>Bipolar Depression</u>-(aka bipolar disorder, manic-depression and manic-depressive illness). In this depression, the lows cycle and alternate with extreme highs. It’s like an emotional up and down rollercoaster or like a windstorm hits a person’s emotions and he/she is tossed about. This extreme fluctuation in moods from high highs and low lows may be attributed to an imbalance in brain chemistry which can be treated successfully with balance-restoring medications.

<u>Psychotic Depression</u>-This is a more severe form of depression in which a person may demonstrate auditory and/or visual hallucinations; they hear voices and see things that others don’t see. People with psychotic depression may also have delusional thinking. They cannot rationally judge the consequences of their

actions and may be in serious danger of harming or even killing themselves and/or others. A person with this type of depression is in need of immediate attention.

<u>Postpartum Depression- </u>About 10% of new mothers experience/develop PPD. It is most common in women who have already experienced some form of depressive illness. Most women suffer from a down feeling for the first few days after giving birth. With PPD the symptoms linger on and are prolonged and increase in their severity and can become incredibly disabling. If untreated, PPD can last for months or even years. * Case history-This brings to mind a female client I worked with who has 3 children; ages 3, 5 and 9. She reported having high levels of irritability and being short with her husband and children and an overall feeling of unease. I worked with her for a period of time and then referred her for a medication evaluation. She saw a psychiatrist who prescribed medication for her and determined that she had been dealing with PPD from the birth of her first child and she was now dealing with the residual cumulative effective layered with the last two births. So PPD can last for months or years.

<u>Seasonal Affective Disorder-</u>SAD This is a subtype of depression. Research suggests that SAD arises out of some people's sensitivity to seasonal changes in the amount of available light. With SAD, some people are depressed during the winter months as there is less daylight.

Manifestation in African American Women-The average AA person in American is more likely than an average Caucasian to suffer from depression. Many AA think that depression or the blues is necessary condition of life and something to be endured. Often, when an African American (AA) woman consults with a health professional, she is frequently told that she is hypertensive, run down, or tense or nervous. She may be prescribed antihypertensive medication, vitamins or mood elevating pills; or she may be informed to lose weight, learn to relax, get a change of scenery or get more exercise. In essence, the root cause(s) are not explored and she may leave the office feeling defeated, unheard and misunderstood. The personal bias or prejudice or racist attitudes of an attending health professional also may adversely impact a correct diagnosis of depression. Oh, she's just overweight and needs to lose weight and she will feel better. She's probably too lazy do exercise. These kinds of biases, these kind of unattended blind spots or blinders, this kind of ignorance will prevent a patient from receiving an accurate diagnosis and proper care.

A diagnosis of clinical depression in an AA woman is also likely to be missed because of the myriad or constellation of other factors that may also be present. For example, AA women have greater risk factors for the development of

depression. These risk factors include having been a **victim of abuse or violence; poverty**, **chronic or serious illnesses such as cancer, heart disease, and diabetes**. It is thought that people with chronic illnesses have immune systems that have been compromised and weakened and therefore this makes the person more susceptible to develop other illnesses and that there is an actual change in the physiology of the individual which can lead to the development of depression. The risk factors I've mentioned are also referred to as **Co-morbid conditions** of co-existing conditions which make it difficult to sift out the diagnosis of clinical depression from other existing conditions. For example, a person may present for ETOH (alcohol) abuse. This person may also be depressed as alcohol is a depressant. The challenge then is to determine if the alcohol abuse is the cause of the depression or if the depression was initially present and the person's alcohol abuse is exacerbating the depression. Other risk factors that contribute to depression in AA women are that AA women live in a majority dominated society in which our heritage is often undervalued as well as our gender and culture. AA is frequently at the lower end of the political and economic spectrum. With this being the case, sometimes there is less access to services, an AA is likely to be uninsured or underinsured and therefore will not access mental health services due to costs. AA woman and this can be said of women in general and of other ethnicities but women are often in multiple roles as we attempt to survive and advance economically. We are often juggling the responsibilities of work with caring for other, be it children and or grandchildren; in some cases great grandchildren, elderly parents. Many of us are attempting to perform these same functions and roles with limited and/or fixed income. In many instances these same responsibilities or roles are being filled by seniors who may have even retired. These retirees in essence then never really get to retire as they now have the responsibility to raise another entire family or families. Depression often goes untreated in AA and persons over the age of 65. There is the common misconception that symptoms demonstrated are a normal part of the aging process. You may have engaged in or overheard a conversation which follows. "How is Aunt Sally?" "Oh, she's fine. She's asleep." "Asleep? It's only 4:30 PM!" "Girl, you know Aunt Sally goes to bed at 4:30 and is asleep by 4:31. Old people sleep more you know." The fact that Aunt Sally is retiring early can be a symptom of depression (sleep disturbance-sleeping more or less than usual) but may be overlooked as such and instead falsely associated with a function of aging.

Treatment-

According to Dr. Freda Lewis-Hall, a psychiatrist who has worked extensively with the AA community, more than 80% of people with clinical depression can successfully recover and resume normal, happy and productive lives. I want to add the caveat and amend normal and happy because each individual may define these terms differently and I tend to think that being restored to a level of

functioning that is productive or the restoration of balance within a given family system.

Medication
SSRIs-Selective Serotonin Reuptake Inhibitors
Celexa (citalopram)
Lexapro (Escritalopram oxalate)
Paxil (paroxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

SNRIs-Serotonin Nor epinephrine Reuptake Inhibitors
Cymbalta
Effexor

MAOIs Monoamine Oxidase Inhibitors
Nardil (phenelzine)

Tricyclics
Adapin (doxepin)
Anafranil (clomipramine)
Elavil and Endep (amitrptyline)
Norpramin (desipramine)
There are a variety of medication options available to treat depression. Rather than go into these extensively or in any detail, what I mainly want to convey about medication is that in many instances it is warranted. The most important thing I can say to you about medication is to ask questions and be informed. Do not just take medication because a doctor prescribes it but ask questions about the medication, know how to spell it, know how to pronounce it, know what color it is and what it is being prescribed for. Inform your doctor about other medications you are taking so that she may best be informed about any medication side effects or if certain medications may be contraindicated due to other conditions. ASK. You have a right to know and must become your own advocate in your mental health.

Hospitalization

Therapy- (Individual, Group, types of therapy-Cognitive Behavioral Therapy (CBT), Psychodynamic, Interpersonal
Short-term Dynamic and Psychoanalytic Therapies)

My personal favorite is a combination of therapy with a qualified mental health professional in conjunction with medication (if warranted). A thoughtful, sensitive, culturally competent mental health professional will be able to not only make an

accurate diagnosis of depression but also to effectively treat the client/or patient. This is best done when a clinician invests the time to complete a detailed assessment and asking the questions to garner the necessary information.

Spirituality/Faith Tradition
As I move to close, I want to address the importance of Spirituality and depression. I address this issue last not because it is of lesser importance but precisely the opposite. It was important for me to lay the above as a foundation or an appetizer if you will and now comes the main entrée, the meal or the feast. I believe that there is great power inherent in the use of one's faith tradition, religious beliefs and spiritual practices in the treatment of depression. I greatly subscribe to the prescription of prayer. What most concerns me is when individuals misuse their faith tradition to berate someone who has depression and to minimize their relationship with God to state that they must not really believe otherwise they would not seek the counsel of a therapist or take medication. If you have heard someone say or even if you have been guilty of this yourself, raise your hand; "Girl, all you have to do is pray and He will work it out"; "Don't claim that spirit of depression, it is nothing but the work of the Satan or the devil." "Girl, let me get my oil and anoint you and rebuke that spirit in the name of Jesus". Some of you are laughing as this is familiar to you. It is not my intention to offend or mock but want I want to say to you as a person of great faith who practices spiritual practices and am a uniquely qualified mental health professional, theses phrases can do great harm. I am here to tell you that your faith tradition, whatever it may be, does not; I repeat DOES NOT have to compete with the care provided by a mental health professional. I know of a woman that I worked with a few years ago that had been seeing a therapist and was actively involved in church. She was taking medication for depression. Bible verse: Matthew 7:6 "Do not cast your pearls before swine." She shared this with someone she believed she could trust and this person judged her, berated her and told her that she was faithless and that if she really believed in God that she would not take medication and that her taking medication was a demonstration of her unbelief in God. Mental health is a part of our overall health-spiritual health, physical health, emotional health, financial health/wealth etc. Mental illness is just as important as our physical health. A person manages his/her diabetes with medication and/or diet just in the same way that you treat/medicate your spiritual health with participation in corporate worship, daily spiritual practices etc. You wouldn't dare say to a diabetic," Honey, you don't need to take that pill today or administer that pinch or shot, just take it to the Lord in prayer and He will make it all right." Yes, He will make it all right by endowing you with wisdom, by bestowing upon you the gift of discernment so that you will be obedient and compliant with directives from your physician to be a good steward over your temple, your body and take your medication. The same is true with our mental health.

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I intend to facilitate workshops in churches in our communities whereby women, especially those that are emotionally overweight (which is unresolved, unexpressed emotions that manifests in being physically overweight) are supported and educated to learn how to harness the power of the Word of God to realize and live their faith. It has long burdened me and I have grown weary of witnessing people emote on a Sunday morning but yet come Monday morning, these same individuals are heavy hearted and unable to translate the healing power of God into their daily lives.

I'd like to close with the powerful words of poet extraordinaire, Maya Angelou; I want to support women to "rise" "into a day break that is wondrously clear". I want to provide an opportunity for women to tell their stories, to make sense out of what has previously been a chaotic journey on a road filled with twists and bends and dips. I want women to provide their narratives and gain clarity and direction for their future for having done so. I again wish to thank Marilyn and Larry Cohen of the Naomi Ruth Cohen Charitable Foundation as well as Pastor Bentley and his helpmeet Sister Joan Bentley for the opportunity to share with you today. It is my great hope that you will have me again.