Dr. Adam Kaplin, Psychiatrist, Joins Scientific Advisory Board

Dr. Kaplin completed his undergraduate training at Yale University in 1988 where he graduated magna cum laude with a B.S. in Biology. He completed his M.D. and Ph.D. training at the Johns Hopkins School of Medicine in 1996, where he was a Medical Science Training Program awardee. Since 1999 Dr. Kaplin has served as the Chief Psychiatric Consultant to the Multiple Sclerosis (MS) and Transverse Myelitis™ Centers at Johns Hopkins University School of Medicine. He is an integral member of the clinical and research endeavors of these centers, with an expertise in investigating the biological basis of depression and cognitive impairment in MS, and the care of patients afflicted with these complications. Dr. Kaplin was selected as the NIH/NIMH Outstanding Resident of the year in 1998, and a Future Leader in Psychiatry by Emory University in 2002.

Dr. Kaplin agreed to sit down with us, to help us break the silence on the taboo topic of depression and its special relationship with MS.

Dr. Adam Kaplin on Depression and MS

The word "depression" is used frequently in our culture. What is the difference between sadness and depression?

Depression is a constellation of symptoms. Often sadness is one of the symptoms, although you can have depression without sadness. Cough is also a symptom, one which is often seen in pneumonia. Sadness is to depression what cough is to pneumonia. With pneumonia, you often but not always have a cough. Having a cough does not necessarily mean that you have pneumonia. With depression you must consider the company the sadness keeps—what other symptoms accompany it. With sadness, a positive event will change your mood. With depression, your mood does not respond to positive events or news; it is as though your mood thermostat is stuck on cold.

What are some of the symptoms of depression?

Generally a person who has 5 of the following 9 symptoms, which must include either decreased interest or low mood, and which lasts for greater than two weeks is clinically depressed. This is according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the main diagnostic reference of Mental Health professionals in the United States: 1) decreased interest (or pleasure) and/or; 2) low mood; 3) increased or decreased sleep; 4) increased or decreased appetite; 5) feelings of guilt or worthlessness; 6) subjective sense of fatigue or low energy; 7) poor concentration; 8) feeling/appearing as though one's thoughts and actions are either slowed down (e.g., dragging) or sped up (e.g., agitated); and 9) thoughts of death or suicide.

For people with MS, there are three common indicators of depression: 1) an unresponsive low mood, 2) loss of self-esteem (i.e. loss of feelings of competence in the areas that give individuals pride in themselves, work and family being primary examples, and 3) failure to participate and progress in rehabilitation and their own recovery.

Are there stages of depression?

Depression, especially the biologically-driven depression that is typical to MS comes in three types—serious, severe and suicidal. Without treatment, individuals may progress from low mood with fewer than the five symptoms typically associated with depression, and become worse and worse until their lives are at jeopardy. Recognition, evaluation and treatment are key to stopping and reversing this dangerous progression.

How common is depression in the U.S. and worldwide?

If you literally go door-to-door in the U.S. at any given time, 5% of individuals in any community will suffer from depression. At some point in their lifetime, 17% of the overall population will have suffered from depression. Women are twice as likely to suffer from depression than men. Depression is democratic: it affects people all over the world from every race, ethnicity and socioeconomic background. According to a 2001 report by the World Health Organization (WHO), major depression is the leading cause of disability worldwide, when measured as years of life lived with disability.

How common is depression among MS survivors?

The prevalence of depression in MS is higher than among all other neurologic diseases, and in fact among all other medical conditions in general. Some 50 to 60% of people with MS have clinical depression over the course of their lifetime. Prior to having MS, the rates of depression among MS survivors are consistent with those of the general population. It is following the onset of MS, with the effects of this disease on the person's brain and life, that the rates of depression skyrocket. If you went door-to-door in any community, you would find one-quarter of the people living with MS would be depressed. And interestingly, there is no correlation between level of disability and depression. But there is a correlation between certain symptoms—like pain—and depression. Although patients with ALS, or Lou Gehrig's disease, lose neurological control and generally die within 3 to five years of diagnosis, they do not experience greater incidences of depression than people in the general population. This is because, unlike MS survivors, their illness does not affect the part of the brain that regulates mood.

Is depression genetic?

Depression does run in families. But not everyone who has a family history of depression will become depressed. With MS, you do not need a family history to become susceptible to depression, and there isn't a significant increase in the rate of depression in MS survivors with a family history of depression.

How dangerous is depression?

At some point during the course of their illness, 80% of depressed people have some thoughts of wanting to kill themselves. Five to 15% of severely depressed people will end their lives. Suicide is the third leading cause of death in the general population's 25 to 45 age group, and the third leading cause of death among MS survivors from all age groups. I paraphrase our former Surgeon General Dr. David Satcher in saying that we fail to realize that far more Americans die from suicide than from homicide. Suicide is just not something people like to talk about, and therefore it all too often goes unnoticed and unaddressed.

What should I do if I think that I am depressed?

Talk to your primary care doctor and your neurologist first so that they can help you assemble a team of physicians who will work together on your behalf to help you stabilize your health. This is particularly important when you are in crisis. If you are having an exacerbation and are prescribed high-dose steroids (which worsen depression in up to 25 to 30% of cases) you need your neurologist to be able to call your psychiatrist to discuss whether the benefits of the drugs outweigh their side effects. I encourage you to get treated and to educate yourself on your illness. The National Institute of Mental Health (NIMH) sponsors a personal website, http://www.lorenbennett.org/dart.htm, a clearinghouse on national organizations, support groups and hotlines in the U.S. and Canada.

If I think I am depressed should I go to a therapist or a psychiatrist?

Generally, a psychiatrist is a physician who is trained in treating illnesses that affect people's moods, thoughts, and behavior, and uses both talk therapy and medications. A psychologist, counselor or social worker is not trained to help differentiate the effects of neurologic or medical illnesses from depression and cannot prescribe medication. With severe depression, "talk" therapy alone, the mainstay of non-physician therapists, is not effective. A psychiatrist can prescribe medication, which will stabilize you to the point where therapy can be effective. You cannot talk your way out of a severe biological depression provoked by MS.

If I think my loved one is depressed, what should I do to help him or her?

Encourage your loved one to seek professional treatment. It is not uncommon for a patient to tell me that he or she has come to see me because of an ultimatum from a spouse. Support your loved one in practical ways. Encourage him or her to eat right, to get out of the house, to get exercise and to maintain structured activities like work and regular social outings, which distract from the illness and facilitate recovery. People with depression often struggle more in the hours after work and on the weekends, when there is more free time, and during unstructured times.

Why is it so difficult for people to admit that they are depressed?

Depression is often dismissed as a reaction to life's circumstances; life is stressful. But everyone who is under stress does not automatically become depressed. There is a lot of stigma surrounding mental illness. Patients will tell me, "My wife thinks I am depressed. But I am not crazy!" The big secret is 20% of women and 10% of men are depressed in this country. What is crazy is not getting help—doing the same thing with the same negative result—when help is available.

I am a caregiver of an MS survivor who constantly feels angry, resentful—and guilty about what has happened to our lives. Why do I feel this way?

There are three main points I would like to share: 1) When someone is given the diagnosis of MS, it doesn't just affect them; it affects their loved ones, too. 2) All attention typically becomes focused on the patient, and caregivers often buy into the idea that time for themselves is time stolen from their loved ones. As a result, caregivers typically neglect their social lives, their work and their health. 3) I often ask caregivers if they remember the safety instructions that they are given on an airplane: In case of disaster always put on your own oxygen mask first, so that you can be in the position to care for a child or someone less able. If you don't take care of yourself, you are not going to be able to care for someone with an illness.

A patient with MS in the hospital typically has a whole team of doctors to look after him or her. In cases where people are severely disabled by MS, if anything happens to the caregiver, the person with MS could end up in a nursing home. Sometimes I will make a trip to the hospital, and that visit will be just for the spouse; I won't even see the patient.

Dr. Adam Kaplin's Three Take-Home Messages About Depression and MS

Depression is a symptom of MS no different than any other symptom of the illness such as loss of vision or bladder control. Depression in MS occurs as a result of the insult to the central nervous system and its effects on the brain. Depression is **not** a result of personal weakness and people with depression can**not** just snap out of it on their own.
Depression can have devastating consequences: Suicide, a result of severe depression, is the third leading cause of death in the general population, and one of the most common and preventable causes of death in patients with MS.
Depression in MS is completely treatable. You can get help and get back in the driver's seat.