The episode is going to focus on mental health so the structure will be slightly different.

Please look at the list below and think of personal tips/anecdotes/ you can share.

Also let me know if something is missing or unneeded.

- ★ **Mental health patreon**
- ★ **Introduce everyone**
- ★ **Personal Status updates**
- ★ **Fortson's Article about mental health: Elvis read**
- ★ **Clarify we are not professional health experts (though Rosie is a healthcare provider) and just sharing what we know.**

We discuss symptoms of

- ★ **Situational Depression vs Clinical-**

Situational depression is a short-term form of depression that occurs as the result of a traumatic event or change in a person's life. "Adjustment disorder with depressed mood" is another name for this.

Triggers can include:

- divorce
- loss of a job
- the death of a close friend
- a serious accident
- other major life changes, such as retirement

Situational depression stems from a struggle to come to terms with dramatic life changes. Recovery is possible once an individual comes to terms with a new situation. For instance, following the death of a parent, it may take a while before a person can accept that a family member is no longer alive. Until acceptance, they may feel unable to move on with their life.

Symptoms can include:

- listlessness
- feelings of hopelessness and sadness
- sleeping difficulties
- frequent episodes of crying
- unfocused anxiety and worry
- loss of concentration
- withdrawal from normal activities as well as from family and friends

- suicidal thoughts

Most people who experience situational depression begin to have symptoms within 90 days of the triggering event.

Clinical depression is also known as major depression or major depressive disorder. It is severe enough to interfere with daily function. A doctor or psychiatrist can diagnose clinical depression. Clinical depression is more severe than situational depression. The (DSM-V) classifies clinical depression as a mood disorder. Disturbances in levels of certain chemicals — known as neurotransmitters — may be to blame.

However, other factors are likely to play a role, for example:

- genetic factors may influence an individual's response to an experience or event
- major life events can trigger negative emotions, such as anger, disappointment, or frustration
- alcohol and drug dependence also have links to depression
- Depression can also alter a person's thought processes and bodily functions.

★ **Suicidal issues:**

Suicide prevention/help:

- Call 1800-273-TALK to speak to a crisis counselor anytime of day.
- Text "hello" or "help" to 741741 for resources and access to someone to talk to.

How to help others:

Mental Health First Aid teaches the acronym **ALGEE**.

1. **ASSESS** for risk of suicide or harm: The best way to find out if someone is considering suicide and determining the urgency of the situation is to ask them:

- Are you having thoughts of suicide?
- Do you have a plan to kill yourself?
- Have you decided when you'd do it?
- Do you have everything you need to carry out your plan?

IMPORTANT NOTE: Some people believe that mentioning suicide might cause someone to consider suicide for the first time. This is not true, so do not be afraid of this outcome. You're much more likely to help someone feel less alone if they were considering it.

If they have a plan and are ready to carry out that plan, call 911 immediately. How you respond to other answers will depend on the situation, but always call 911 if you're unsure. It's better to be safe than for someone to lose their life.

Additionally, not having a plan doesn't mean they're not in danger. All thoughts of suicide must be treated seriously.

If you think the person is in danger, you need to keep the person safe. Stay with them for as long as you can, because an actively suicidal person shouldn't be left alone. If you can't stay, find someone who can until help arrives.

If you determine the person is having suicidal thoughts but there's no immediate danger, engage in conversation with them if possible.

2. **LISTEN** non judgmentally: If the person does not appear to be in a crisis, encourage them to talk about what they're thinking and how they're feeling. It can be hard to hear someone you know is experiencing distress, but when you listen and genuinely care, you can have a calming, positive impact on them, and you can start to learn more about what is at the root of their suicidal thinking.

You may not fully understand what they're going through, and that's OK. What's important is that you're accepting of what they're saying, acknowledge it and genuinely try to imagine what it might be like for them. Staying patient and respectful can make a world of difference.

If, while you're listening, you discover they may in fact be in crisis, return to the ASSESS step in No. 1.

3. **GIVE** reassurance and information: Reassurance is crucial, as people having suicidal ideation may not have much hope. Clearly state to them that suicidal thoughts are often associated with a treatable mental illness, and if you feel comfortable, you can also offer to help them get the appropriate treatment. You can also tell them that thoughts of suicide are common, and that you don't have to act on them.

4. **ENCOURAGE** appropriate professional help: If you are concerned for the person's immediate safety, call 911. If you're concerned but it's not an immediately urgent situation, make sure the person has a safety contact available at all times, whether it's a loved one or mental health professional.

If the crisis has passed, or the person wasn't actively suicidal but has suicidal thoughts, encourage the appropriate psychological or medical help. If you want to provide further

assistance, offer to call medical professionals if they don't already have one to schedule an appointment, or do any of the other legwork required to get them help. Remind them that recovery is possible with treatment.

5. **ENCOURAGE** self-help and other support strategies: Ask the person to think about what has helped them in the past. Perhaps a particular therapist, family member, friend or spiritual leader has given them support, or maybe a particular community, like a church or club, has been there for them. They should tap into their support system as much as possible during this time.

REMEMBER: These steps don't have to necessarily go in order. Apply them in whichever way makes sense for you and the person you're addressing.

- ★ **Basics and beginner for taking care of yourself**
- ★ **Next steps when that stops working: when and how to get help.**

- ★ **Free and insurance covered options:**

Lemonaid Health is a great resource. It's not cheap, but for $95 you talk to a mental health professional who can prescribe you medicine (included in your $95) that is sent from their pharmacy. They also check up on you frequently. It can all be done through an app!

- ★ **Differences between Counselor, Therapist, Psychologist and Psychiatrist:**

Skill Sets:

- Counselors work with individuals or groups, and many professionals draw from a variety of experiences to connect with patients.

- Therapists receive training to connect with clients. A therapist usually chooses a field of specialization, such as marriage or family therapy, and guides clients to help them overcome personal issues.

- Psychologists require strong analytical and observational skills. These professionals conduct research, diagnose disorders, and supervise interns. Generally speaking, psychologists have more in common with therapists and counselors than psychiatrists.

- Psychiatrists are medical doctors (M.D. or D.O.) who specialize in preventing, diagnosing, and treating mental illness. A psychiatrist's training starts with four years of

medical school and is followed by a one-year internship and at least three years of specialized training as a psychiatric resident. A psychiatrist is trained to differentiate mental health problems from other underlying medical conditions that could present with psychiatric symptoms. They also monitor the effects of mental illness on other physical conditions (such as problems with the heart or high blood pressure), and the effects of medicines on the body (such as weight, blood sugar, blood pressure, sleep, and kidney or liver functioning).

Education

- Many counselors require a bachelor's degree, although some certifications as counselors may not even require an associate's degree. For instance, some states license or certify addictions counselors with an associates degree, or a combination of college credits, professional seminars, and years of experience working in addictions. Addictions and behavioral disorder counselors working in private practice must be licensed and therefore must have a master's degree. Mental health counselors must also earn master's degrees in order to gain licensure.

- Therapists should earn at least a master's degree. At this level, students choose a field of specialty while completing their master's degrees. After earning a four-year bachelor's degree, each aspiring professional must complete a 2-3 year master's and supervised clinical work.

- Each psychologist needs a doctoral degree, and most professionals complete a 3-4 year Ph.D., Ed.D., or Psy.D. Doctoral degrees in psychology require a bachelor's and master's in psychology, along with some professional experience. This degree also requires supervised clinical work and most states require around two years of clinical supervision before the individual would be eligible for licensure.

- As a doctor, a psychiatrist is licensed to write prescriptions. Many mental disorders -- such as depression, anxiety, ADHD, or bipolar disorder -- can be treated effectively with specific drugs.

Patient Care

- Counselors typically provide guidance to their clients. Because counseling is a broad field, the way counselors approach patient care widely varies, though counselors usually stay within their fields of expertise.

- Therapists often need licenses to practice, so therapists only see patients that fall under their area of expertise. Many therapists use a specific theoretical orientation to guide their practice, such as cognitive behavioral therapy, which allows clients to take their negative thoughts and replace them with positivity. Other commonly used clinical models include psychodynamic, attachment theory, family systems, and IFS.

- Psychologists possess the highest level of education and only see specific cases in their field of expertise. These professionals may also adopt a specific theoretical orientation such as cognitive behavioral therapy or psychoanalysis to treat their patients.

- If you are working with a psychiatrist, a lot of the treatment may be focused on medication management. Sometimes medication alone is enough to treat the mental illness. Sometimes a combination of medication and psychotherapy or counseling is needed. If that is the case, the psychiatrist may provide the psychotherapy, or the psychiatrist may refer you to a counselor or other type of mental health professional.

★ **Non-med options**
★ **If meds are recommended**
★ **Treating symptoms (libido, weight gain/loss)**

★ **Different types of meds:**

Antidepressants:

- Selective serotonin reuptake inhibitors (SSRIs). Doctors often start by prescribing an SSRI. These medications generally cause fewer bothersome side effects and are less likely to cause problems at higher therapeutic doses than other types of antidepressants are. SSRIs include fluoxetine (Prozac), paroxetine (Paxil, Pexeva), sertraline (Zoloft), citalopram (Celexa) and escitalopram (Lexapro).
- Serotonin and norepinephrine reuptake inhibitors (SNRIs). Examples of SNRI medications include duloxetine (Cymbalta), venlafaxine (Effexor XR), desvenlafaxine (Pristiq) and levomilnacipran (Fetzima).
- Atypical antidepressants. These medications don't fit neatly into any of the other antidepressant categories. More commonly prescribed antidepressants in this category include trazodone, mirtazapine (Remeron), vortioxetine (Trintellix), vilazodone (Viibryd)

and bupropion (Wellbutrin SR, Wellbutrin XL, others). Bupropion is one of the few antidepressants not frequently associated with sexual side effects.

- Tricyclic antidepressants. Tricyclic antidepressants — such as imipramine (Tofranil), nortriptyline (Pamelor), amitriptyline, doxepin and desipramine (Norpramin) — tend to cause more side effects than newer antidepressants. So tricyclic antidepressants generally aren't prescribed unless you've tried other antidepressants first without improvement.
- Monoamine oxidase inhibitors (MAOIs). MAOIs — such as tranylcypromine (Parnate), phenelzine (Nardil) and isocarboxazid (Marplan) — may be prescribed, often when other medications haven't worked, because they can have serious side effects. Using an MAOI requires a strict diet because of dangerous (or even deadly) interactions with foods — such as certain cheeses, pickles and wines — and some medications, including pain medications, decongestants and certain herbal supplements. Selegiline (Emsam), an MAOI that you stick on your skin as a patch, may cause fewer side effects than other MAOIs. These medications can't be combined with SSRIs.

★ **Stimulants for adhd**

Stimulants used to treat ADHD include:

- Methylphenidate
- Amphetamine
- Dextroamphetamine
- Lisdexamfetamine Dimesylate

Note: In 2002, the FDA approved the non-stimulant medication atomoxetine for use as a treatment for ADHD. Two other non-stimulant antihypertensive medications, clonidine and guanfacine, are also approved for treatment of ADHD in children and adolescents. One of these non-stimulant medications is often tried first in a young person with ADHD, and if response is insufficient, then a stimulant is prescribed.

Stimulants are also prescribed to treat other health conditions, including narcolepsy, and occasionally depression (especially in older or chronically medically ill people and in those who have not responded to other treatments.

★ **Anxiety drugs**

Benzodiazepines used to treat anxiety disorders include:

- Clonazepam
- Alprazolam
- Lorazepam

Short half-life (or short-acting) benzodiazepines (such as Lorazepam) and beta-blockers are used to treat the short-term symptoms of anxiety. Beta-blockers help manage physical symptoms of anxiety, such as trembling, rapid heartbeat, and sweating that people with phobias (an overwhelming and unreasonable fear of an object or situation, such as public speaking) experience in difficult situations. Taking these medications for a short period of time can help the person keep physical symptoms under control and can be used “as needed” to reduce acute anxiety.

- Buspirone (which is unrelated to the benzodiazepines) is sometimes used for the long-term treatment of chronic anxiety. In contrast to the benzodiazepines, buspirone must be taken every day for a few weeks to reach its full effect. It is not useful on an “as-needed” basis.

★ **Antipsychotics**

Antipsychotic medicines are primarily used to manage psychosis. The word “psychosis” is used to describe conditions that affect the mind, and in which there has been some loss of contact with reality, often including delusions (false, fixed beliefs) or hallucinations (hearing or seeing things that are not really there). It can be a symptom of a physical condition such as drug abuse or a mental disorder such as schizophrenia, bipolar disorder, or very severe depression (also known as “psychotic depression”).

Antipsychotic medications are often used in combination with other medications to treat delirium, dementia, and mental health conditions, including:

- Attention-Deficit Hyperactivity Disorder (ADHD)
- Severe Depression
- Eating Disorders
- Post-traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder

Antipsychotic medicines do not cure these conditions. They are used to help relieve symptoms and improve quality of life.

Older or first-generation antipsychotic medications are also called conventional "typical" antipsychotics or “neuroleptics”. Some of the common typical antipsychotics include:

- Chlorpromazine
- Haloperidol
- Perphenazine
- Fluphenazine

Newer or second generation medications are also called "atypical" antipsychotics. Some of the common atypical antipsychotics include:

- Risperidone
- Olanzapine
- Quetiapine
- Ziprasidone
- Aripiprazole
- Paliperidone
- Lurasidone

According to a 2013 research review by the Agency for Healthcare Research and Quality, typical and atypical antipsychotics both work to treat symptoms of schizophrenia and the manic phase of bipolar disorder.Several atypical antipsychotics have a “broader spectrum” of action than the older medications, and are used for treating bipolar depression or depression that has not responded to an antidepressant medication alone.

★ **When is it safe to stop taking meds**

PLEASE talk to your doctor about stopping your medication. DO NOT just stop taking it. This increases your risk for suicidal ideation and mood changes exponentially. The best way to stop taking a medication is a gradual weaning.

★ **How to wean and if it’s needed**

All of the medications talked about in this episode should not be stopped abruptly. They all require weaning. This is dependent on how your body handles the medication and what your doctor thinks is best. We cannot in good conscience tell you how to wean off of your medication.

Do we do a silly question at the end? Ideas for one?