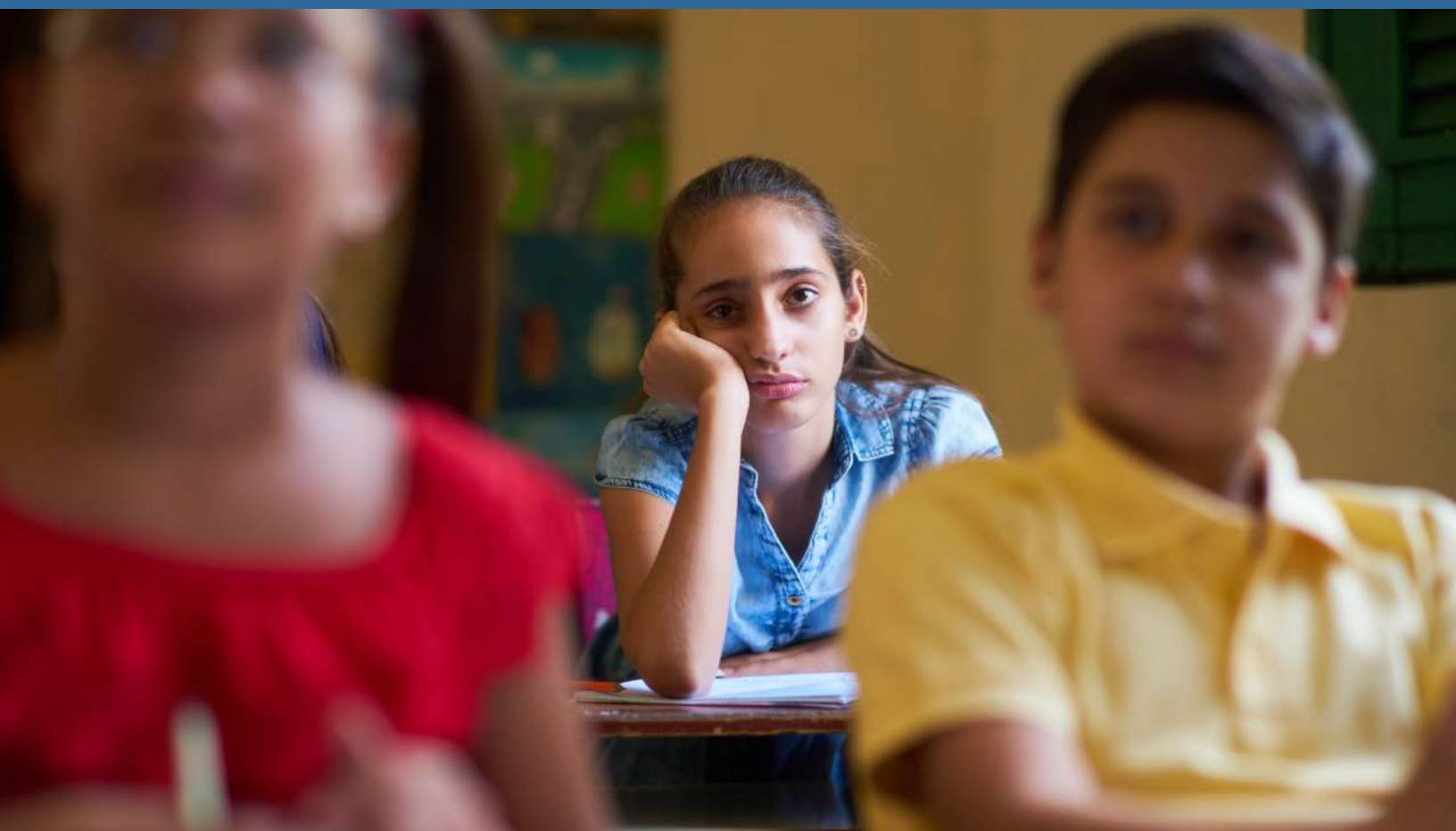
Mindful
Continuing Education

Addressing the Rise in Anxiety and Depression



Introduction

Over the past couple of years, the rates of anxiety and depression have increased at an alarming rate, impacting not only those suffering but also placing an increased burden on the behavioral health profession. Recent studies indicate an increase in the percentage of adults reporting clinically relevant symptoms of anxiety and depression, particularly since the COVID-19 pandemic. Behavioral health professionals must be able to accurately diagnose these conditions and effectively treat those suffering. This course will explore the prevalence, symptoms, assessment, and treatment of anxiety and depression. In addition, it will address how the increased demands for treatment is impacting behavioral health professionals.

Anxiety: Prevalence, Symptoms & Risk Factors

Anxiety is an emotion characterized by apprehension and physical symptoms such as tension when a person anticipates impending danger, catastrophe, or adversity. The body often responds to the perceived threat with muscle tension, increased breathing rate, and increased heart rate. Anxiety differs from fear in that fear is an appropriate, present-oriented, and short-term response to a clearly identified and specific threat. On the other hand, anxiety is a future-oriented, long-acting response to a broad focus on a minimal threat (APA Dictionary, 2023).

Risk factors for anxiety disorders include socio-demographic factors (female sex, non-Hispanic ethnicity, African American race, marital status of widowed or divorced, or poverty), psychosocial factors (stressful life events or smoking and alcohol use), and physical and mental health factors (presence of other mental health condition or parental history of mental disorders). Research has shown that anxiety disorders frequently overlap with depressive disorders, with one study finding that rate to be as high as 67% (USPSTF, 2022).

Anxiety disorders are the most common mental health disorders. Approximately 30% of adults will experience anxiety at some point in their lifetime. The most common types of anxiety disorders are explored below, including the yearly estimated percentage of adults in the United States who experience the type of anxiety disorder, the symptoms, and risk factors.

Separation Anxiety

Separation anxiety is experienced by 0.9-1.9% of the population in the United States. It is typically experienced in childhood or adolescence, when young people are placed in a situation where they are apart from the person they feel attached to. Adults may also experience this during a separation from a loved one, which may lead to feelings of anxiety. The fear, anxiety, or avoidance must be persistent, last at least six months for adults, and cause impairment socially, occupationally, or in other areas of functioning. Diagnostic criteria also include meeting at least three of the following symptoms:

- Recurrent excessive distress when anticipation or experiencing separation from home or major attachment figures.
- Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
- Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
- Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
- Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
- Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
- Repeated nightmares involving the theme of separation.
- Repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated (American Psychiatric Association, 2013).

Risk factors for separation anxiety in adults are often seen after a life stress, especially a loss. Other life stressors can include leaving the parental home, entering a romantic relationship, or becoming a parent (American Psychiatric Association, 2013).

Generalized Anxiety Disorder

Generalized Anxiety Disorder is experienced by 2.9% of the population in the United States. It involves excessive worry and anxiety over a range of concerns where the person has experienced symptoms for more days than not over the last six months. The person finds it difficult to control their worry. The symptoms cause impairment in social, occupational, or other areas of functioning. Diagnostic criteria include meeting at least three of the following symptoms:

- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep) (American Psychiatric Association, 2013)

Risk factors for generalized anxiety disorder include:

- behavioral inhibition
- negative affectivity
- harm avoidance
- childhood adversities
- parental overprotection
- diagnosis of other mood disorders, particularly major depressive disorder (American Psychiatric Association, 2013)

Agoraphobia

Agoraphobia is diagnosed in 1.7% of the population in the United States. It involves excessive & irrational fear of being in open or unfamiliar places, leading to avoiding public situations where escape may be difficult. Diagnostic criteria include a marked fear or anxiety about two or more of the following situations:

- Using public transportation
- Being in open spaces
- Being in enclosed spaces (shops, theaters, cinemas)
- Standing in line or being in a crowd
- Being outside the home alone

AND

- The situations are avoided (travel is restricted) or are endured with marked distress or anxiety about having a panic attack or panic-like symptoms or require a companion's presence
- The agoraphobic situations almost always provoke fear or anxiety
- The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context
- The fear, anxiety, or avoidance is persistent, typically lasting six months or more
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in important areas of functioning (American Psychiatric Association, 2013)

Risk factors for agoraphobia include:

- Behavioral inhibition
- Negative affectivity
- Anxiety sensitivity
- Negative events in childhood (separation or death of a parent)
- Stressful events (being attacked or mugged)
- Heritability for agoraphobia is 61% (the strongest genetic factor among all the phobia diagnoses) (American Psychiatric Association, 2013)

Panic Disorder

Panic disorder is experienced by 2-3% of the population in the United States. It is recurrent and unexpected panic attacks that are linked to the constant worry of having another attack, concern about the consequences of the attacks, and significant change in behavior due to the attacks (avoiding situations, being hypervigilant). During the panic attack, at least four of the following symptoms occur:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Chills or heat sensations
- Paresthesias (numbness or tingling sensation)
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or “going crazy”
- Fear of dying (American Psychiatric Association, 2013)

Risk factors for panic disorder include:

- Negative affectivity and anxiety sensitivity
- Having an attack that does not meet the full criteria of a panic attack
- Childhood experiences of physical and sexual abuse
- Smoking

- Life stressors leading up to the first attack
- Parents diagnosed with anxiety, depressive, or bipolar disorders
- Past history of respiratory disorders such as asthma (American Psychiatric Association, 2013)

Social Anxiety Disorder

Social anxiety disorder is experienced by 7% of the United States population. It involves the doubt individuals have about their social status, role, and behavior. It can include the fear of social situations where embarrassment may happen or the risk of being negatively evaluated by others. The fear, anxiety, or avoidance causes significant impairment in social, occupational, or other important areas of functioning. Diagnostic criteria for social anxiety disorder include:

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (having a conversation, meeting unfamiliar people), being observed (eating or drinking), and performing in front of others (giving a speech).
- The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (will be humiliating or embarrassing; will lead to rejection or offend others).
- The social situations almost always provoke fear or anxiety.
- The social situations are avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- The fear, anxiety, or avoidance is persistent, typically lasting six months or more (American Psychiatric Association, 2013).

Risk factors for social anxiety disorder include:

- Behavioral inhibition and fear of negative evaluation
- Childhood maltreatment and adversity

- Immediate family members with anxiety disorders increase the risk by two to six times higher (American Psychiatric Association, 2013)

Specific Phobia

Specific phobias are diagnosed in 7-9% of the United States population. Specific phobias are persistent and irrational fears of a specific situation, object, or activity. Examples include animal phobia (fear of dogs, snakes, etc.), natural environment phobia (fear of heights, water, storms, etc.), blood-injection-injury phobia (fear of seeing blood, getting an injection, or experiencing an injury), situational phobias (fear of flying, elevators, bridges, etc.), or other types of fears that would be considered excessive and unreasonable by most and cause the individual to experience extreme behavioral reactions or avoidance (psychiatry.org, 2021 & APA Dictionary, 2023). The diagnostic criteria for a specific phobia include:

- Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood)
- The phobic object or situation almost always provokes immediate fear or anxiety
- The phobic object or situation is actively avoided or endured with intense fear or anxiety
- The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context
- The fear, anxiety, or avoidance causes significant distress or impairment in social, occupational, or other important areas of functioning and lasts for at least six months (American Psychiatric Association, 2013)

Risk factors for a specific phobia include:

- Negative or traumatic experience with the feared situation or object
- 75% of people with a specific phobia fear more than one situation or object
- Negative affectivity & behavioral inhibition
- Parental overprotectiveness, parental loss, or parental separation
- Physical and sexual abuse

- Some genetic susceptibility for some phobias (American Psychiatric Association, 2013)

Depression: Prevalence, Symptoms & Risk Factors

Depression is one of the most common mental health conditions in the United States. Depression is a negative affective state that can range from unhappiness and discontent to extreme feelings of sadness, pessimism, and despondency. Often physical, cognitive, and social changes occur, including altered eating and sleeping habits, lack of energy or motivation, difficulty concentrating and making decisions, and withdrawal from social activities. Research on depression shows that genetic, psychological, biological, and environmental factors all impact the development of depression. Risk Factors include a family history of depression, major life changes, trauma, stress, physical illness, and certain medications (APA Dictionary, 2023 & NIHM, 2022).

General risk factors for depression include biological and environmental factors. Experiencing trauma or adverse life events such as childhood sexual abuse, intimate partner violence, comorbid mental health diagnoses, substance abuse, and physical illnesses such as stroke and cardiovascular disease all increase the risk of developing depression. The heritability of depression is substantiated by the fact that those with first-degree relatives with a depression diagnosis are two to three times more likely to develop depression compared to the general population (USPSTF, 2022).

Major Depressive Disorder

Major depressive disorder is diagnosed in 7% of the United States population. It is depression that lasts for at least two weeks, and the person experiences a depressed mood or loss of interest or pleasure. It impacts the person's ability to work or socialize, or other areas of function. Diagnostic criteria also include experiencing at least five of the following symptoms nearly every day:

- Depressed mood most of the day, nearly every day
- Diminished interest or pleasure in all or almost all activities
- Significant weight loss without dieting, weight gain, or a decrease or increase in appetite

- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, a suicide attempt, or a suicide plan (American Psychiatric Association, 2013)

Risk factors for Major Depressive Disorder include:

- Negative affectivity
- Adverse childhood experiences (multiple and diverse types increase risk)
- Stressful life events
- An immediate family member diagnosed with MDD increases a person's risk by two to four times more than the general population.
- Other mental health disorders, particularly substance abuse, anxiety, and borderline personality disorder.
- Chronic or disabling medical conditions, including diabetes, morbid obesity, and cardiovascular disease (American Psychiatric Association, 2013).

Persistent Depressive Disorder

Persistent depressive disorder is diagnosed in 0.5-1.5% of the United States population. It typically has less severe symptoms of depression, but it lasts for at least two years, and the person has not experienced a cessation of symptoms for more than two months. Diagnostic criteria also include meeting at least two of the following symptoms and that they are experienced nearly every day:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue

- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness (American Psychiatric Association, 2013)

Risk factors for persistent depressive disorder include:

- Childhood parental loss or separation
- An immediate family member diagnosed with a depressive disorder increases a person's risk (American Psychiatric Association, 2013)

Perinatal and Postpartum Depression

3-6% of the population experience this in the United States. A woman can experience it during pregnancy or after birth. This type of depression is officially categorized in the DSM-V as Major Depressive Disorder with the specifier of “with peripartum onset.” It is diagnosed if the woman meets the diagnostic criteria for major depressive disorder and the symptoms only occur during pregnancy or within four weeks post-delivery. Additionally, 50% of postpartum major depressive episodes begin prior to delivery. Not only may the woman experience “baby blues,” this type of depression is often accompanied by severe anxiety and panic attacks (American Psychiatric Association, 2013).

Peripartum-onset mood disorders can also present with psychotic features. This is most often associated with infanticide, where the mother experiences command hallucinations to kill the infant or delusions that the infant is possessed. Postpartum mood episodes with psychotic features occur in 1 in 500 to 1 in 1,000 deliveries and are more common in first pregnancies. In addition, the risk of postpartum mood episodes with psychotic features increases for women who have experienced postpartum mood disorders in the past (the risk of reexperiencing symptoms in subsequent deliveries is 30%-50%), have a history of depressive or bipolar disorders or have a family history of bipolar disorders (American Psychiatric Association, 2013).

General risk factors for developing major depressive disorder with peripartum onset include stress, lack of social support, current or past abuse, history of depression, and partner dissatisfaction (USPSTF, 2022).

Seasonal Affective Disorder (SAD)

SAD is diagnosed in 0.5-3% of the United States population. It is a type of depression that ebbs and flows with the changing seasons and decrease of light during the winter months and typically subsides in the spring and summer with increased light. The prevalence of winter-type seasonal patterns is increased with higher latitudes, and younger people are at a higher risk for winter depressive episodes. In the DSM-V, SAD is categorized as the diagnosis of Major Depressive Disorder with the specifier of "with seasonal pattern." The diagnostic criteria include the following:

- There has been a regular temporal relationship between the onset of major depressive episodes and a particular time of the year (fall or winter)
- Full remissions also occur at a characteristic time of the year (spring)
- In the last two years, two major depressive episodes have occurred that demonstrate a temporal seasonal relationship, and no nonseasonal major depressive episodes have occurred during the same period
- Seasonal major depressive episodes substantially outnumber the nonseasonal major depressive episodes that may have occurred over the person's lifetime
- This specifier DOES NOT apply to psychosocial stressors such as seasonal unemployment or school schedule (American Psychiatric Association, 2013)

Symptoms of major depressive disorder that are most often seen in seasonal patterns include:

- Low energy
- Hypersomnia
- Overeating
- Weight gain
- Craving carbohydrates (American Psychiatric Association, 2013)

Anxiety: Assessment & Screening Tools

The U.S. Preventive Services Task Force (2022) recommends that all adults over the age of 19 be screened for anxiety, including pregnant or postpartum women. Their recommendations include all adults, even if they have not been diagnosed with a mental health condition or are showing symptoms. They recommend that those who have never received a screening in their lifetimes should have one and then future screenings will depend on clinical judgment, based on risk factors, comorbid conditions, and life events and stressors. This recommendation for a broad screening for all adults is due to underdetection being common and delays in treatment frequently occurring. One study of primary care patients found that only 41% with an anxiety disorder were receiving needed treatment.

The task force recommends using the following screening tools:

- Generalized Anxiety Disorder (GAD) scale (GAD-7 can be found in Appendix)
- Edinburgh Postnatal Depression Scale (EPDS)-Anxiety subscale (EPDS can be found in Appendix, Anxiety subscale questions are #3, #4, & #5)
- Geriatric Anxiety Scale (GAS) (GAS-10 can be found in Appendix)
- Geriatric Anxiety Inventory (GAI) (USPSTF, 2022)

Depression: Assessment & Screening Tools

The U.S. Preventive Services Task Force (2022) recommends all adults over the age of 19, including pregnant and postpartum people, be screened for depression in the primary care setting. The rationale for a broad screening for depression includes not only depression's impact on a person's quality of life and relationships but also when left untreated, it is linked to increased mortality, higher risk for cardiovascular conditions, and it's exacerbating effects on other comorbid conditions. Through routine screenings, people struggling with depression can be identified and receive the treatment they need in a timely manner.

Recommended screening tools for depression include:

- Patient Health Questionnaire (PHQ-9) (See Appendix)
- Center for Epidemiologic Studies Depression Scale (CES-D)

- Edinburgh Postpartum Depression Scale (EPDS) (See Appendix)
- Geriatric Depression Scale (GDS) (See Appendix)(USPSTF, 2022)

Anxiety: Treatment

Anxiety can often be treated successfully with medications, psychotherapy, or a combination of both. For some people, mild to moderate anxiety can be managed with lifestyle changes; these will be explored as well.

Medications

Antidepressants

Antidepressants are frequently prescribed to treat anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) are the ones typically prescribed. By increasing the level of serotonin in the brain, mood, appetite, and sleep are all then regulated. This all leads to improved mood and lower levels of anxiety. These medications can take up to 12 weeks before the person experiences the full effectiveness. For more details on SSRIs & SNRIs, including side effects, refer to the section under Depression Treatment (NYU, 2023).

Buspirone

Buspirone is an antianxiety medication typically used to treat generalized anxiety disorder, and it usually takes a few weeks before it is effective. Buspirone works by decreasing the amount and action of serotonin in certain parts of the brain. Buspirone can be prescribed as a standalone antianxiety medication or in combination with an antidepressant, which seems to enhance its effects. It is usually prescribed as a standalone treatment for people who do not respond well to or do not want the side effects of antidepressant medication (Richardson, 2023).

Side Effects

- Nervousness
- Restlessness

- Unusual Excitement
- Drowsiness
- Difficulty sleeping, having nightmares or vivid dreams
- Dryness of the mouth
- Sweating or clamminess
- Blurred vision
- Ringing in the ears
- Diarrhea
- Unusual weakness
- Muscle spasms, pains, stiffness, or cramping (Richardson, 2023)

Beta Blockers

Beta-blockers are prescribed off-label for the treatment of social phobia or specific anxieties. Some examples of drugs that are in this category include acebutolol (Sectral), bisoprolol (Zebeta), carvedilol (Coreg), propranolol (Inderal), atenolol (Tenormin), metoprolol (Lopressor). These substances work by reducing the physical symptoms of anxiety, such as shaking, heart palpitations, and sweating, without the side effects of antianxiety medications. Beta-blockers work to treat anxiety by blocking the fight-or-flight hormone adrenaline. When the adrenaline can't bind to receptors, it prevents an adrenaline overload that triggers extreme anxiety or panic attacks. Beta-blockers only address the physical effects of anxiety, not any underlying chemical imbalances or psychological reasons for anxiety (Cleveland Clinic, 2022).

Side Effects

- Cold Hands
- Headaches
- Dizziness
- Dry mouth or eyes
- Fatigue

- Insomnia, sleep changes, and nightmares
- Irregular heart rhythms
- Slow heart rate
- Low blood pressure
- Nausea
- Constipation (Cleveland Clinic, 2022)

Benzodiazepines

Benzodiazepines may be prescribed under limited circumstances. Because they are addictive sedatives, they are usually only used to relieve extreme, acute anxiety in the short term. Benzodiazepines have a lower risk of addiction when used occasionally or daily for a limited time frame of a few weeks. The risk for addiction rises when taken for more than a few weeks or at higher dosages. Those with a history of substance abuse should minimize or avoid use as they are at higher risk of addiction. Some examples of drugs that are in this category include clonazepam (Rivotril), alprazolam (Xanax), and lorazepam (Ativan). Also used are bromazepam (Lectopam), oxazepam (Serax), chlordiazepoxide (once marketed as Librium), clorazepate (Tranxene) and diazepam (Valium) (CAMH, 2023).

Side Effects

- Fatigue
- Dizziness
- Sedation
- Loss of balance
- Confusion
- Disorientation
- Amnesia
- Breathing difficulties
- Depression (CAMH, 2023)

Psychotherapy

Cognitive Behavioral Therapy

CBT is one of the most well-researched and successful treatments for anxiety disorders. It works by targeting maladaptive thoughts and behaviors and improving the distressing emotions of anxiety. CBT is used to treat generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder. CBT treatment usually occurs weekly and is short-term (12-16 sessions with booster sessions available if needed). CBT works to treat anxiety disorders by addressing dysfunctional thinking patterns, distressing feelings or physiological experiences, and unproductive behaviors. When these three pieces interact together, they reinforce each other, and distressing levels of anxiety occur.

Cognitive interventions address adaptive thinking by identifying biased thinking and negative perceptions and using cognitive restructuring to arrive at more realistic interpretations of situations. Behavioral experiments are also part of cognitive restructuring. Individuals are encouraged to test maladaptive beliefs to find out if there is any factual evidence to support their belief.

Behavioral Interventions for anxiety disorders focus on exposure therapy. The theory behind exposure therapy is that people avoid experiences, events, and thoughts that they believe will lead to a negative experience. Avoiding these things reinforces negative beliefs. Through careful, repeated exposure, without avoidant behaviors, situations will likely become more comfortable and will be less associated with the potential for a disastrous outcome (Curtiss et al., 2021).

While other psychotherapy modalities have shown some success in treating anxiety disorders, Cognitive Behavioral Therapy continues to be seen as the gold-star treatment at this time.

Exposure Therapy

As previously stated, exposure therapy is a type of behavioral therapy that is effective in treating phobia and anxiety disorders. Exposure therapy uses in vivo exposure or imaginal exposure. During in vivo exposure therapy, the person is purposefully exposed to the feared object or situation. This can be challenging as often types of exposure must happen in public, leading to risking the person's confidentiality, and it may be too

expensive or difficult to replicate the feared situation (such as the fear of flying). In situations where in vivo exposure is not possible, imaginal exposure therapy can be used as an alternative where the person will imagine an interaction with the feared situation or object. Imaginal exposure has its limitations, and in order for it to be effective, the person must be willing and able to adequately imagine the situation and take the time to analyze the thoughts and feelings around the fear (Baghaei et al., 2021)

Depression: Treatment

Depression can often be treated successfully with medications, psychotherapy, or a combination of both. In severe cases that do not respond to standard treatments, brain stimulation therapies may be helpful.

Medications

Antidepressants help improve how one uses brain chemicals to control mood. Antidepressants take four to eight weeks to begin working. People taking antidepressants usually begin seeing improvements in their sleep, appetite, and concentration levels before they begin to see an improvement in mood. While most antidepressants are safe, there can be an increased suicide risk, particularly within the first few weeks of starting the medication or if the dosage amount is changed. Anyone prescribed an antidepressant should be monitored closely for worsening depression, unusual behavior, and suicidal ideations. With proper use and dosage, antidepressants should reduce the risk of suicide (NIHM, 2022 & Mayo Clinic, 2019)).

The three most common classes of medications used to treat depression are:

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs are the most frequently prescribed medications. Some examples of drugs that are in this category include sertraline (Zoloft), paroxetine (Paxil), fluoxetine (Prozac), and citalopram (Celexa). SSRIs work by increasing the level of serotonin in the brain. Serotonin is a neurotransmitter (a chemical messenger) that carries signals between neurons (brain nerve cells).SSRIs block the reabsorption of serotonin into the neurons, making it more available and improving the transmission of messages between the neurons (Mayo Clinic, 2019).

Side Effects

- Agitation
- Nausea
- Sexual problems, including low sex drive or inability to have an orgasm
- Dizziness
- Headaches
- Insomnia
- Increased anxiety
- Exhaustion
- Diarrhea
- Dry mouth
- Tremors (Cleveland Clinic, 2019)

Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)

SNRIs treat long-term pain and anxiety, as well as depression. Examples of SNRIs include venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta). SNRIs work by increasing the level of serotonin and norepinephrine in the brain. Serotonin and norepinephrine are both neurotransmitters (chemical messengers) that carry signals between neurons (brain nerve cells). SNRIs block the reabsorption of serotonin and norepinephrine into the neurons, making them more available and improving the transmission of messages between the neurons. It changes the brain chemistry and the brain nerve cell communication to regulate mood (Mayo Clinic, 2019).

Side Effects

- Headache
- Dizziness
- Nausea
- Heavy sweating

- Dry mouth
- Constipation
- Insomnia
- Sexual problems including low sex drive or inability to have an orgasm (Cleveland Clinic, 2019)

Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)

NDRIs treat depression and seasonal affective disorder. Bupropion (Wellbutrin) is the only drug in the category. Norepinephrine and dopamine are both neurotransmitters (chemical messengers) that carry signals between neurons (brain nerve cells). NDRIs block the reabsorption of norepinephrine and dopamine into the neurons, making them more available and improving the transmission of messages between the neurons.

Side Effects

- Headache
- Insomnia
- Dry mouth
- Constipation
- Nausea
- Tiredness
- Tremor
- Increased sweating (Cleveland Clinic, 2019)

Psychotherapy

Counseling can help those with depression learn new ways of thinking and behaving and how to change the habits that may be contributing to their depression. There are several evidence-based therapies that have been shown to decrease depression symptoms. They include:

Cognitive-Behavioral Therapy (CBT)

CBT is one of the most documented and validated psychotherapy methods. It is effective in treating major depressive disorder and is often the first treatment recommendation. Intervention strategies are based on modifying a person's dysfunctional behaviors and cognitions (thoughts). CBT for depression focuses on peoples' irrational beliefs and distorted thoughts that perpetuate their symptoms by challenging and altering them. CBT can be offered in individual or group therapy settings. It is short-term (usually around 20 sessions) and problem-focused.

The effectiveness of CBT for depression is dependent on individuals' capability to observe and change their beliefs and behaviors. One technique to address this challenge is by encouraging people to integrate pleasant activities into their day to increase the number and intensity of positive interactions with their environment (Karrouri et al., 2021 & ADAA, 2020).

Interpersonal Therapy (IPT)

IPT explores social issues that maintain depression. IPT's goal for treating depression is to identify the triggers of depressive symptoms or episodes. Triggers may include losses, social isolation, or difficulties in social interactions. The role of the intervention is to facilitate mourning (in the case of bereavement), help individuals recognize their own affect, and resolve social interaction dysfunction by building their social skills and social support. IPT can be offered in individual or group therapy settings. It is short-term and problem-focused. IPT is an effective treatment for mild to moderate depressive episodes (Karrouri et al., 2021 & ADAA, 2020).

Problem Solving Therapy (PST)

PST combines some parts of cognitive and interpersonal therapy. It focuses on defining personal problems, developing multiple solutions, identifying the best ones, and implementing them, followed by assessing their effectiveness. It has shown effectiveness in treating depression, especially among the elderly, those with mild depressive symptoms, and those receiving treatment in a primary care setting (Karrouri et al., 2021 & ADAA, 2020).

Brain Stimulation Therapy

Brain stimulation therapies are used to treat medicine-resistant depression. These treatments include:

Electroconvulsive Therapy (ECT)

ECT involves having a mild electric current passed through the brain to cause a brief seizure. ECT can be used in treatment when medication has been ineffective, medication can not be used safely, or when a rapid response is necessary. It can be particularly effective in situations where a person is experiencing an extreme level of depression, such as catatonia, or in situations where the person is a danger to self or others, and when medications will take too long before they are effective.

The treatment procedure for ECT involves general anesthesia to help the person avoid feeling any discomfort, pain, or anxiety. A muscle relaxant is also given to avoid any strains or injuries during the seizure. During treatment, individuals have a bite guard in their mouth to protect their teeth and soft tissues. In the next step, electrodes are placed on the head at specific spots depending on the needs of the person receiving treatment. A low-level current is delivered and will be increased until the desired results are seen. The electrical current delivery is very brief, usually only lasting a few seconds. The electrical current will cause a seizure due to the delivery of the electrical current, which will cause changes in the brain both electrically and chemically, with the results being an improvement in functioning in the targeted brain areas. Seizures typically last 30-90 seconds, and if for any reason they last longer, the medical provider can inject anti-seizure medications immediately. After the seizure, the person will awake from the anesthesia, and this usually takes 10-15 minutes, with the person being fully awake and walking within 30 minutes. Treatment can be provided in an outpatient setting, three to four times a week for two to four weeks. It works quickly, with most people seeing results after three to five treatments.

ECT is one of the most effective treatments for depression in people who have been medicine or therapy-resistant to treatment. With advances in medicine with anesthesia, it is a safe procedure for most people, even those who are pregnant. It is a positive treatment option for people who can not take medications due to other conditions, such as those with organ function problems or women who are pregnant.

Side Effects

Side effects can include disorientation, confusion, and memory loss, and they may persist throughout the course of treatment. These side effects are usually short-term. Most people's memory loss goes away within a few months post-treatment, but there are some people who experience permanent memory difficulties.

Many people have a negative association with ECT based on how it is portrayed in movies and tv shows. They are often portrayed as painful, scary, and even traumatizing procedures. The actual procedures that are provided by medical professionals in safe and humane ways are rarely shown (NIMH, 2022 & Cleveland Clinic, 2022).

Repetitive Transcranial Magnetic Stimulation (rTMS)

rTMS is a noninvasive treatment of stimulating the brain through brief, high-intensity magnetic pulses. It can be provided in an office setting as it does not require anesthesia. rTMS has been an effective treatment for medicine-resistant major depressive disorder patients.

In rTMS treatment, a helmet with a magnet is placed on the patient's head, or a magnet on an extension arm is placed next to a targeted spot on the patient's head. The patient may feel a tapping sensation from the magnet, and as the pulse strength increases, the patient will experience movement in the hands. This is typically what the treatment provider is looking for to know if the strength is sufficient. The provider will then have the magnet deliver pulses at specific time intervals. Treatment sessions can be between a few minutes and up to half an hour (Cleveland Clinic, 2023).

Side Effects

The most serious but rare side effect is seizures; they happen in 1 in 10,000 cases. Most side effects are mild that only last a few minutes after a treatment session. They include headaches, scalp or neck pain, dizziness, tingling in the face and scalp muscles, temporary tinnitus, and high sensitivity to sound (Cleveland Clinic, 2023).

Vagus Nerve Stimulation (VNS)

VNS is slightly more invasive as it uses an implanted device to stimulate the vagus nerve in the person's neck. It sends regular, mild electric pulses via the vagus nerve to the brain. Once the electric charge reaches the brain stem, it disperses to different areas, changing the way the brain cell functions. It is sometimes referred to as a pacemaker for

the brain. VNS is only approved for persons over 18 years of age who have long-term or recurrent depression that has not responded to at least four antidepressant medication treatments. This treatment is only considered for medicine-resistant depression, as current studies show only 20%-30% of patients receiving VNS report a significant improvement in symptoms.

The vagus nerve is one of 12 cranial nerves that send electrical signals between one's brain and other parts of the head, neck, and torso. The vagus nerve is the longest cranial nerve, and there is one on each side of a person's body that runs from the brainstem to the chest and abdomen. It is part of the body's electrical system linking the heart, lungs, and abdomen to the brain (Cleveland Clinic, 2022).

While it is still not clearly understood how VNS helps depression, it is believed that it changes the level of specific neurotransmitters in the brain that regulate mood. The device is made up of a pulse generator and insulated wire with electrodes at the end. A surgeon makes one incision on the left side of the neck to expose the vagus nerve and a second incision on the upper left chest. The coil electrodes are wrapped around the vagus nerve, and the wire is guided down to the chest incision. There it is connected to a small battery, approximately the size of a silver dollar, where it is placed in a small pocket made over the chest muscles. The surgery lasts 45 to 90 minutes. The device is then programmed to deliver electrical pulses to the vagus nerve at specific frequencies and for a certain amount of time for the on/off cycle (Cleveland Clinic, 2022).

Side Effects

A person should not feel the stimulation or be able to tell when it's happening. There may be times when individuals feel a tickling in the throat or neck, and they may experience voice hoarseness or a mild cough when the stimulation is on. Other more serious side effects include infection, damage to the vagus nerve, headaches, vocal cord paralysis, and facial muscle weakness (Cleveland Clinic, 2022).

Coping Strategies and Alternative Treatments for Anxiety & Depression

Physical Activity for Depression

For some people with mild to moderate depression, exercise can work as well as antidepressant medications. High-intensity exercise triggers the release of feel-good

endorphins, and regular low-intensity exercise can provide its own type of benefits. Regular physical activity causes the release of neurotrophic or growth factor proteins. These proteins improve brain function by causing nerve cells to grow and by creating new connections, making the person feel better. Researchers have found people with depressed moods have a smaller hippocampus, the part of the brain that regulates mood. Exercise helps nerve cell growth in the hippocampus, aiding in relieving depression. It may take a few weeks of regular activity before the person begins to notice changes (Harvard Medical School, 2021).

Physical Activity for Anxiety

Aerobic exercise seems to help the most with managing anxiety (a bike ride, dance class, or brisk walk). Exercise can help manage anxiety in a number of different ways. It can act as a distraction from what is causing the anxious mood. Exercise decreases muscle tension which can be a contributing factor to one's body feeling anxious. Exercise increases the heart rate, which impacts brain chemistry, increasing anti-anxiety neurochemicals such as serotonin, endocannabinoids, gamma-aminobutyric acid, and brain-derived neurotrophic factor. Exercise activates the brain's frontal regions, and this area helps control the amygdala, the area of the brain where reactions to real or imagined threats to survival take place (Ratey, 2019).

Sleep

Improving sleep quality improves overall mental health. Research supports that improved sleep reduces depression and anxiety levels. Those struggling with insomnia report higher levels of depression and anxiety. Targeting sleep hygiene treatments may be helpful in reducing the severity of anxiety and depression symptoms. Cognitive behavioral therapy for insomnia (CBTi) is an evidence-based treatment with positive results in improving sleep (Scott et al., 2021)

Nutrition

Skipping meals can aggravate both depression and anxiety. While there are no specific foods or diest that can prevent or treat anxiety or depression, there are some foods that can help support mood. Some studies have shown that carb cravings that come with a depressed mood may be the body's way of trying to boost serotonin. Eating complex carbohydrates such as fruits and vegetables, whole grains, and legumes may help. Eating foods that contain tryptophan, such as turkey, tuna, and chicken also helps boost

serotonin. Additionally, eating protein-rich foods can help boost energy and alertness. Healthy protein sources include legumes, milk, cheese, yogurt, fish, poultry, and soy products (Bruce, 2021).

Nutritional psychiatry is an emerging field of study related to the use of nutritional interventions in the prevention and treatment of mental health disorders. Despite increasing evidence of beneficial effects, nutritional recommendations are provided to psychiatric patients infrequently in clinical practice (Aucoin et al., 2021).

Adoption of a healthy eating pattern that meets food-based dietary recommendations and nutrient requirements is important to prevent, slow the progression of, or manage depressive symptoms, as well as promote optimal mental health (Kris-Etherton et al., 2021).

Depression

Diet is a recognized risk factor for depression, but it is also a modifiable one. In the Supporting the Modification of lifestyle in Lowered Emotional States (SMILES) study, participants diagnosed with major depressive disorder were assigned to either a social support group or a diet counseling group to assist them in following a modified Mediterranean diet. Those who were assigned to dietetic counseling had a greater reduction in their depressive symptoms over the 12-week period compared with those in the social support group. The modified Mediterranean diet consists of consuming recommended servings of whole grains, vegetables, fruit, legumes, low-fat and unsweetened dairy, raw and unsalted nuts, fish, lean red meats, eggs, chicken, olive oil, and limited intakes of sweets, refined cereals, fried food, fast food, processed meats, and sugary drinks. The Dietary Approaches to Stop Hypertension (DASH) diet, which is high in fruits, vegetables, and low-fat dairy and low in saturated fat, has also been shown to improve depressive symptoms. There were mixed results when looking at vegetarian and vegan diets. This may be due to a higher risk for suboptimal intake of essential nutrients such as vitamin B12, iron, and n-3 fatty acids, which are required for optimal functioning of the neuroendocrine system. An appropriately planned vegan or vegetarian diet will meet nutrient requirements. However, without adequate planning, nutrient deficiencies may manifest. Macronutrients of fat, protein, and carbohydrates do not seem to have a significant effect on depression, but added sugars and refined carbohydrates did increase depression symptoms, and higher consumption of fiber, fish and n-3 fats decreased depression symptoms. B vitamins, especially B-12 and folate, when at healthy levels, appear to prevent depressive symptoms. Other vitamin

deficiencies that have been linked to increased depression symptoms include vitamin D, magnesium, and zinc (Kris-Etherton et al., 2021).

Anxiety

Among research focused on carbohydrate consumption, a correlation was found between a higher intake of simple or refined carbohydrates, a higher glycemic index diet or sugar intake, and higher levels of anxiety. Artificial sweeteners had similar effects of increasing anxiety as well. There have been some smaller research studies that have found diets high in protein, and low in carbohydrates reduced anxiety symptoms. Increased tryptophan also appears to reduce anxiety. Supplementing with omega-3 fatty acids reduced anxiety symptoms after three weeks in one study. The research focused on supplementing vitamins and minerals appears to have mixed results at this time. Overall the following foods and supplements were found to help reduce anxiety symptoms:

- Vegetables and Fruit
- Omega-3 Fatty Acids, Alpha-lipoic acid, Omega-9 Fatty acids
- Nuts and Seeds
- "Healthy" dietary patterns, Mediterranean diet, Traditional dietary patterns, Anti-inflammatory diet pattern
- Caloric Restriction
- Fasting or intermittent fasting
- Breakfast consumption
- Broad-spectrum micronutrients
- Vegan diet
- Zinc, Magnesium, Selenium
- Vitamin C, Vitamin E, Choline
- Ketogenic diet
- Food sources of Lactobacillus and Bifidobacterium

- Culinary herbs: turmeric, saffron, soy, green tea, herbal tea, quercetin, resveratrol, and other phytochemicals (flavonoids, polyphenols, carotenoids

The following foods and supplements were found to increase anxiety symptoms:

- High-fat diet, high cholesterol, high trans fat
- Inadequate tryptophan and dietary protein
- High intake of sugar, refined carbohydrates, artificial sweeteners
- "Unhealthy" dietary patterns, typically defined as high in unhealthy fat and refined sugars
- Snacking (Aucoin et al., 2021)

Avoiding caffeine and alcohol

Caffeine and alcohol can exasperate anxiety and trigger panic attacks (NIMH, 2022). Caffeine in moderation can boost one's mood, but too much can cause other complications. Too much caffeine can increase already present feelings of anxiety and stress. Most people know the feeling of an energy boost and the jitters that follow after having an energy drink or a shot of espresso. The caffeine increases one's body's alertness and, in doing so, can cause a person already struggling to become even more anxious. Too much caffeine can also impact sleep, and lack of quality sleep is linked to increasing difficulties and symptoms in those struggling with anxiety and depression. Even if the caffeine does not prevent the person from falling asleep, the sleep quality is going to be poorer with excess caffeine in one's system.

Many people counteract their overconsumption of caffeine by having alcohol in the evening to help decrease the effects of caffeine. Once again, while this may aid in falling asleep, the quality of sleep is going to be poorer. There is also a reciprocal relationship between alcohol and depression. Alcohol consumption may result in increased depression symptoms. In addition, symptoms of depression can cause people to be more vulnerable to alcohol abuse. Feelings of low self-worth and confidence can cause individuals to drink more, which then can make them feel even worse about themselves. It's a vicious cycle where alcohol increases the risk of depression, and depression increases the potential for alcohol misuse. This was a particular concern during the peak of the pandemic when people were reporting increased depressed mood, they were isolated from friends and family, they lost jobs, there were economic hardships, and many people experienced multiple stressors at once. Liquor stores were open through

the height of the lockdown, with many seeing record sales, leading experts to voice numerous concerns about the general population's health and well-being (Mock, 2020).

Mindfulness-Based Interventions

Complementary and integrative-based therapies include mindfulness activities such as yoga, meditation, tai chi, and qi gong. These interventions are best used as complimentary therapies along with medications and/or psychotherapy.

Yoga is an ancient Eastern practice that incorporates physical postures, breath control, and meditation. There are several different styles of yoga that differ in intensity, duration, and emphasis on each component. One study found yoga to be just as effective in treating depression as other exercise routines and medications. Hatha yoga was found to be most effective with anxiety disorders and particularly with panic disorders. Symptom reduction was seen for those with depression and anxiety with just one 60-minute session per week. Optimal amounts and duration varied per person.

Tai chi and qi gong are mind and body practices that incorporate postures and gentle movements with mental focus, breathing, and relaxation. The movements can be done while walking, standing, or sitting. While studies have shown these two modalities to be effective in reducing symptoms in those with depression, the results varied greatly. There were better and more consistent results with those who had anxiety symptoms and participated in tai chi or qi gong, but once again, results varied greatly by study.

Meditation is a form of mental training that requires calming the mind with the goal of achieving a state of "detached observation." There are many different mediation approaches. The ones that seem to have the most impact on people with depression and anxiety disorders include mindfulness-based interventions, mindfulness-based training, mindfulness-based stress reduction, and mindfulness-based cognitive therapy. Although these approaches differ, they all rely on calming the mind as their core modality. Mindfulness-based interventions showed significant improvements in those with depression. In some studies, the results were as positive as evidence-based treatments, including SSRIs. It was less effective with those with anxiety but still showed moderate improvements. Mindfulness-based training was shown to be as effective as cognitive behavioral therapy, other behavioral therapies, and medications for both depression and anxiety (Saeed et al., 2019)

Smartphone Apps

Smartphone apps are effective at reducing symptoms of depression and anxiety. The biggest challenge is creating ones that use engagement techniques to improve regular use. While apps are shown to be an effective intervention, most people stop using apps after 15 days. Apps with the most successful results include some type of guidance component from a therapist or coach. One suggestion to improve the effectiveness of apps is to include a social support component to improve mental health treatment outcomes (Wu et al., 2021).

Virtual Reality

Virtual reality (VR) was first used in the healthcare system with burn patients, using a VR gaming program called SnowWorld. The results reduced the patient's pain perception during wound care. VR is now being explored to see how it can assist in the treatment of depression and anxiety. One effective way is in VR exposure therapy (VRET). It follows the same procedures as traditional exposure therapy, but the feared object or situation is being experienced in a virtual environment instead. A virtual environment provides a greater degree of control for the therapists to customize, reproduce, and tweak several treatment parameters according to the patient's needs. Such a level of customization cannot be achieved in traditional exposure therapy. The risk of privacy intrusion is reduced as everything is confined to a virtual environment. Patients report that VRET is less frightening than in vivo exposure. Other VR treatments are still being researched, as using VR for mental health therapy is a relatively new use of technology (Baghaei et al., 2021)

COVID-19 & Mental Health

Before the COVID-19 pandemic, the estimated global rate of anxiety disorders was 3824.9 per 100,000 people (approximately 298 million people worldwide). After the onset of the COVID-19 pandemic, the global estimated rate of anxiety disorders was 4802.4 per 100,000 people (approximately 374 million people). Before the COVID-19 pandemic, the estimated global rate of major depressive disorder was 2470.5 per 100,000 people (approximately 193 million people). After the onset of the COVID-19 pandemic, the global estimated rate for major depressive disorder was 3152.9 per 100,000 people (approximately 246 million people). Females had a greater increase in

both anxiety disorders and major depression disorder rates than males (Santomauro et al., 2021).

Past research has shown that exposure to media coverage on collective trauma (i.e., mass violence, disease outbreak, or natural disaster) can inform the public but also increase stress symptoms, worry, and perceived risk resulting in other public health issues (Holman et al., 2020).

Holman et al. (2020) found in their research that as COVID-19 infections and deaths increased in the United States, related acute stress and depressive symptoms increased. Their research identified three areas to improve communities and individual resilience. These included supporting individuals with preexisting conditions, mitigating secondary stress, and monitoring media exposure.

- **Supporting Individuals with Preexisting Conditions**

  Those with preexisting physical or mental health issues were more likely to experience acute stress. Furthermore, they were the most likely to experience depressive symptoms. Prior life stressors such as bullying and other types of victimization were linked to young adults' emotional responses to the pandemic. These results show the importance of establishing mental health services for those with prior mental health concerns or a history of victimization.

- **Mitigating Secondary Stress**

  Secondary stressors, including employment loss, income loss, and lack of necessities, were predictors of acute stress and depressive symptoms. Communities dealing with the effects of COVID-19, including illness, death, loss of employment, and economic difficulties, would benefit from support services to help offset the mental health strain of complex loss and grief. Addressing the secondary stressors would reduce the feelings of loss, which increases psychological distress and leads to more stress.

- **Monitoring Media Exposure**

  Exposure to pandemic media coverage was linked to increased acute stress and depressive symptoms. Daily exposure to pandemic media coverage, increased overall media exposure, and frequency of exposure to conflicting media information all predicted an increase in acute stress and depressive symptoms. This shows the responsibility media should have in presenting consistent messaging to enhance resilience and mental health. The public can better

understand risk and protective factors when they receive clear and consistent communication. Conflicting media coverage increases the public's uncertainty about safety, raising stress, anxiety, and depressive symptoms. Media outlets and representatives should provide accurate, non-sensationalized, and non-contradictory information to the public.

Impacts on Behavioral Health Professionals

Increased Demands

For the past three years, since the onset of the COVID-19 pandemic, the demand for mental health services has risen, particularly in the areas of anxiety, depression, stress-related disorders, and substance abuse. According to the APA's 2022 COVID-19 Practitioner Impact Survey, demand for anxiety and depression treatment is high. Psychologists reported an increase in patients with anxiety disorders (79%) and depressive disorders (66%). Due to this increase in demand, psychologists reported working more hours; these numbers appear to have risen each year (from 15% in 2020 to 38% in 2021, to 43% in 2022 for clinicians who reported seeing more patients than before the pandemic). In addition, 60% reported having no openings for new patients. Some reported no longer having a waitlist due to already having too many people waiting on it (over 50) or the demand being too high to be able to manage a such a list. The percentage of respondents who "agreed" or "strongly agreed" that they felt burned out was (45%) in 2022, slightly down from (48%) in 2021, but both higher than the (41%) reporting burnout in 2020 (APA, 2022).

Emotional Demands

The emotionally demanding aspect of mental health services impacts burnout, job satisfaction, and turnover intention. High levels of burnout within an organization causes poor service consumer/client outcomes, the potential for a contagion effect on colleagues, and increased cost to the organization in terms of high employee turnover and loss of organizational knowledge.

Burnout has two components, exhaustion, and disengagement. Exhaustion is the depletion of energy due to ongoing physical, affective, or cognitive strain.

Disengagement is distancing oneself from work and having negative attitudes toward job tasks, service users, or work in general.

Job demands are the pieces of work that cause stress; they include workload, time pressure, contact demands, physical environment, and cognitive demands. Job resources in the workplace help maintain one's well-being and include feedback, rewards, recognition, job security, job control, supervisor support, and social support (Scanlan & Still, 2019).

Scanlan & Still (2019) found in their study that there was a correlation between job demands and exhaustion. They found rewards and recognition reduced disengagement and turnover intention among mental health providers, and that feedback was key to job satisfaction. The emotional demands of a job were the strongest predictor for exhaustion.

Zoom Fatigue

During the pandemic, most behavioral health programs and services shifted to being offered via zoom or other video platforms. Zoom fatigue emerged during the pandemic as the use of virtual communication rose, and the overuse of zoom and other virtual platforms led to tiredness, worry, or burnout. There are a number of components that impact zoom fatigue.

One reason zoom meetings are draining is due to the slight delay in audio to video. Even with a good internet connection, the slight delays in virtual verbal responses negatively affect our interpersonal perceptions.

A second reason appears to be connected with the cost-benefit system we unconsciously have, and how social interactions happen seem to be part of this psychological rewards system. This can be illustrated in magnetic resonance imaging (MRI), which shows that live face-to-face interactions are associated with greater activation in the same brain regions involved in reward when compared to other types of viewing. Therefore, increased active social connection is correlated with increased perceived reward, affecting the neurological pathways modulating alertness versus fatigue.

A third component is eye contact. Direct mutual gaze improves connection, including faster responses, more memorization of faces, and increased likeability and attractiveness. These things that naturally make interactions rewarding are compromised over video or screens. On video, one must look directly at the camera to

appear to be making eye contact with the other person, and during group calls, it can be impossible to create eye contact between any two people.

A fourth element of zoom fatigue is video requires a higher level of cognitive effort. Social cues, such as facial expressions, gestures, and body language, are difficult to visualize since the physical environment is not shared and may not be captured on video. Without the help of these nonverbal cues that we have all relied on our whole life to socio-emotionally assess each other and bond, more cognitive and emotional effort is required to compensate for this shortcoming.

Finally, a fifth piece to zoom fatigue is increased virtual appointments, usually linked to increased sedentariness. Physical activity has a large impact on reducing fatigue, up to 40%. Being in lockdown with limited opportunities to leave one's home, along with increased amounts of time sitting at one's computer holding virtual sessions or groups, reduced most people's physical activity and increased fatigue (Lee, 2020).

Burnout, Secondary Stress Trauma, & Self-Care

Burnout can and does lead to professional impairment, including inadequate assessment, treatment, and evaluation. That is one reason the National Association of Social Workers added a self-care section to their Code of Ethics in 2021. It states,

> *"Professional self-care is paramount for competent and ethical social work practice. Professional demands, challenging workplace climates, and exposure to trauma warrant that social workers maintain personal and professional health, safety, and integrity. Social work organizations, agencies, and educational institutions are encouraged to promote organizational policies, practices, and materials to support social workers' self-care."*

Components of burnout for social workers and other behavioral health professionals include emotional exhaustion, depersonalization (seeing clients as problems rather than human beings), and lack of self-efficacy (feeling like no matter how hard one works, nothing changes). Specific symptoms of burnout may include physical exhaustion, headaches, insomnia, and low morale (Gushwa, 2022).

Secondary traumatic stress is a type of emotional stress that happens when a person hears about the first-hand trauma of someone else. Most mental health providers are frequently exposed to stories of violence, abuse, and human cruelty, making them at risk of developing secondary traumatic stress. Symptoms of secondary traumatic stress are

much the same as those of PTSD and can include disconnecting from others, insomnia, impaired memory, depression, and emotional numbing (Gushwa, 2022).

The COVID-19 pandemic increased mental health providers' stress by creating a collective trauma. Early in the pandemic, many feared that contracting the virus would mean imminent death. Mental health providers experienced these same unknowns while continuing to provide services to people experiencing those same fears. As a result, many providers had to overlook or discount their own fears in order to provide needed support to their clients. This collective trauma has exacerbated burnout and secondary traumatic stress rates among mental health providers (Gushwa, 2022).

Fortunately, many professionals have become aware of repercussions from COVID-19, and have taken action. For example, the APA's 2022 COVID-19 Practitioner Impact Survey found that most psychologists have sought peer consultation and support to manage burnout (60%), were able to practice self-care (77%), and have maintained a positive work-life balance (63%) (APA, 2022).

NASW recommends the following self-care practices to meet the challenges of working in the mental health field.

- Making time for self-reflection, rest, and relaxation is essential for mental and physical health.
- Staying connected with our friends, family, colleagues, and support systems.
- Avoiding burnout and overwork.
- Knowing the signs of compassion fatigue and seeking support as needed.
- Setting appropriate boundaries with work, family, and media.
- Allowing yourself to feel your feelings.
- Engaging in social justice work that is important to you (NASW, 2023).

Conclusion

The rates of anxiety and depression were rising and spiked significantly with the onset of the COVID-19 pandemic. Despite the number of people struggling, there is still a large part of the population who are not receiving treatment. Some may be minimizing their symptoms through substance use, or failure to acknowledge their own struggles, and

they may be unable to access mental health services. For this reason, there has been a recommendation for universal screening for depression and anxiety for the general adult population.

Due to these high rates, behavioral health professionals should be knowledgeable about the different types of anxiety (generalized anxiety disorder, agoraphobia, panic disorder, social anxiety disorder, specific phobia disorder) and depression (major depressive disorder, persistent depressive disorder, major depressive disorder with peripartum onset, and major depressive disorder with seasonal onset). Providers should have an understanding of screening tools to use with clients, evidence-based treatment therapies, alternative treatments for medicine-resistant diagnoses, and adjunctive therapies for those who are hesitant to try medication initially or who wish to explore supportive programs in addition to evidence-based treatments.

The high demand for mental health treatment has placed additional stress on behavioral health professionals. Providers should be assessing themselves for burnout and secondary traumatic stress symptoms regularly. They should seek support to deal with the emotional demands placed on them by their jobs and establish routine self-care practices to take care of themselves and help mitigate their daily exposure to stressors.

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Appendix: Screening Tools

GAD-7

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). *Generalized Anxiety Disorder 7 (GAD-7)* [Database record].

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge:	0	1	2	3
2. Not being able to stop or control worrying:	0	1	2	3
3. Worrying too much about different things:	0	1	2	3
4. Trouble relaxing:	0	1	2	3
5. Being so restless that it is hard to sit still:	0	1	2	3
6. Becoming easily annoyed or irritable:	0	1	2	3
7. Feeling afraid as if something awful might happen:	0	1	2	3

Column totals: _____ + _____ + _____ + _____ = Total Score _____

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring:

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PHQ-9

Kroenke, K. & Spitzer, R.L. (2002). The PHQ-9: A new depression and diagnostic severity measure. Psychiatric Annals, 32, 509-521.

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed or hopeless:	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down:	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television:	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3

Column totals: _____ + _____ + _____ + _____ = Total Score _____

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
?	?	?	?

Scoring PHQ-9:

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."

PHQ-9 total score for the nine items ranges from 0 to 27.

0-4 none-minimal depression

5-9 mild depression

10-14 moderate depression

15-19 moderately severe depression

20-27 severe depression

Major Depressive Disorder is likely if:

5 or more items are checked as at least "more than half the days"

Either item 1 or 2 is checked as at least "more than half the days"

Edinburgh Postnatal Depression Scale 1 (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

*3. I have blamed myself unnecessarily when things

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4. I have been anxious or worried for no good reason

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

*5 I have felt scared or panicky for no very good reason

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

*6. Things have been getting on top of me

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping

- Yes, most of the time

- Yes, sometimes
- Not very often
- No, not at all

*8 I have felt sad or miserable

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

*9 I have been so unhappy that I have been crying

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

*10 The thought of harming myself has occurred to me

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Administered/Reviewed by _____ Date _____

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786 .

Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale 1 (EPDS)

Postpartum depression is the most common complication of childbearing. 2 The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov > and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum > and Depression after Delivery <www.depressionafterdelivery.com >.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Geriatric Depression Scale - Short Form

Retrieved January 2023: https://web.stanford.edu/~yesavage/GDS.html

MOOD SCALE

(short form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**

2. Have you dropped many of your activities and interests? **YES** / NO

3. Do you feel that your life is empty? **YES** / NO

4. Do you often get bored? **YES** / NO

5. Are you in good spirits most of the time? YES / **NO**

6. Are you afraid that something bad is going to happen to you? **YES** / NO

7. Do you feel happy most of the time? YES / **NO**

8. Do you often feel helpless? **YES** / NO

9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO

10. Do you feel you have more problems with memory than most? **YES** / NO

11. Do you think it is wonderful to be alive now? YES / **NO**

12. Do you feel pretty worthless the way you are now? **YES** / NO

13. Do you feel full of energy? YES / **NO**

14. Do you feel that your situation is hopeless? **YES** / NO

15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes, a score > 5 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression.

Geriatric Anxiety Scale – 10 Item Version (GAS-10)

Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the PAST WEEK, INCLUDING TODAY by checking under the corresponding answer.

	Not at all (0)	Sometimes (1)	Most of the time (2)	All the time (3)
1. I was irritable.				
2. I felt detached or isolated from others.				
3. I felt like I was in a daze.				
4. I had a hard time sitting still.				
5. I could not control my worry.				
6. I felt restless, keyed up, or on edge				
7. I felt tired.				
8. My muscles were tense.				
9. I felt like I had no control over my life.				
10. I felt like something terrible was going to happen to me.				

GAS-10 Scoring Instructions

Items 1 through 10 are summed to provide a Total Score. Each item ranges from 0 to 3.

Score Distribution for GAS-10 (N = 556)

Raw	T-Score	Percentile	Descriptive Category
1	42	21	Minimal
2	44	30	Minimal
3	46	34	Minimal
4	48	45	Minimal
5	51	53	Minimal
6	53	63	Minimal
7	55	70	Mild
8	57	75	Mild
9	59	82	Mild
10	61	90	Moderate
12	66	95	Severe
14	70	98	Severe
16	74	99	Severe
18	79	99	Severe
24	92	99	Severe
30	104	99	Severe

The primary citations for the GAS are as follows:

Segal, D. L., June, A., Payne, M., Coolidge, F. L., & Yochim, B. (2010). Development and initial validation of a self-report assessment tool for anxiety among older adults: The Geriatric Anxiety Scale. Journal of Anxiety Disorders, 24, 709-714.

Mueller, A. E., Segal, D. L., Gavett, B., Marty, M. A., Yochim, B., June, A., & Coolidge, F. L. (in press). Geriatric Anxiety Scale: Item response theory analysis, differential item functioning, and creation of 10-item short form (GAS-10). International Psychogeriatrics.

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