A Primer on Depression

Opening Comment

The scientific study of depressive illnesses is advancing with new discoveries and new understandings revealing themselves every day.

You are encouraged to visit the National Institute of Mental Health website where you can search for current findings, reports and other information on depression, bipolar disorder, etc. (*www.nimh.nih.gov)*

How many people are affected by depression?

The National Institute for Mental Health (NIMH) estimates that 6.7% of US adults suffer from depression in a 12 month period (approximately 15.2 million individuals) of whom 4.5 million experience severe depression. Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 6.4% of US adults suffered from depression in 2008 (approximately 14.5 million individuals). NIMH estimates that in any given 12 month period 51.7% of depression sufferers receive treatment; however, only 19.6% of those suffering from depression receive minimally adequate treatment. In other words, nearly 12 million sufferers of depression are not receiving minimally adequate treatment.

NIMH estimates prevalence for bipolar disorder among US adults at 2.6% (approximately 5.9 million individuals) of whom nearly 5 million are classified as severe. 48.8% are receiving treatment in a 12 month period; however, only 18.8% of those suffering from bipolar disorder receive minimally adequate treatment. In other words, nearly 4.8 million sufferers of bipolar disorder do not receive minimally adequate treatment.

More facts about depression:

- The average age of first onset of depression is 32 years old.
- The average age of first onset for bipolar disorder is 25 years old.
- Women are 70% more likely than men to experience depression (lifetime).
- The average duration of all depressed episodes is 20 weeks.
- Nearly 70% of those suffering from major depression find a treatment that works.
- 20% of patients who develop major depression have not recovered in 2 years.
- 12% of patients who develop major depression have not recovered after 5 years.
- A study of bipolar disorder type 1 (characterized by episodes of mania rather than hypomania) revealed that 37% experienced a recurrence of mania or depression within a year, 60% within 2 years, and 73% within 5 years.
- Treatment of bipolar disorder is difficult and may include a combination of medications in an attempt to control mania without inducing a depressive episode. Intensive therapy has also proven helpful, along with collaborative care, when used in conjunction with medications.

Why are so many people going untreated for depression?

Millions needlessly suffer from a depressive illness for months or even years because of the lack of knowledge on their part or on the part of their family, friends, or family doctor. Many are unaware that they suffer from an illness than can and should be medically treated. It is all too easy to ignore the warning signs of depression. Lawyers and judges, in particular, tend to dismiss the idea that we can have problems that may require the help of someone else to solve. We are trained to solve the problems of others and, therefore, can take care of our own needs. As a result of this attitude, the depression worsens until the individual cannot reach out for help even if he or she wanted to. Feelings of unworthiness, anxiety, despair, helplessness, hopelessness and an indifference to life itself lead to isolation and sometimes suicide.

Embarrassment also prevents many people from seeking help. They are afraid of being labeled Amentally ill@. Depression carries a stigma because most people do not understand the true nature of depressive illnesses, what causes them and how they are treated. Misconceptions and misunderstandings abound when we talk of depression, so most people are reluctant to ask for help even if they think they may be depressed. The result is prolonged suffering and misery often leading to failed marriages, friendships, jobs and, sometimes, suicide.

These tragedies can be avoided. By studying what causes depression, learning to recognize the warning signs and knowing where to turn for help, we can help ourselves, our friends and our families to access appropriate treatment before serious difficulties set in - difficulties that tend to compound the depression making it harder to treat.

What causes depression?

Our earliest understanding of depression was that it was the result of an imbalance of the chemicals in our brain that influence our thoughts, emotions and behavior. These chemicals (Aneurotransmitters@) are the messengers that facilitate communication between our brain cells (neurons). Neurons communicate with one another through neural pathways that connect one another with various areas of the brain. For the past forty years depression has been seen as the result of an imbalance of two particular neurotransmitters (serotonin and norepinephrine) which could be corrected by anti-depressants, therapy or, in severe cases, electroconvulsive therapy.

New insights into depression are emerging – one such insight is the Adiathesis-stress model@. Some scientists are questioning the idea that an imbalance of norepinephrine or serotonin is the primary culprit for depression. Rather they are looking at how inherited factors and early childhood experiences affect the development and functioning of the prefrontal cortex and the amygdala as well as other major areas of the brain. (The following is taken from Psychology Today, April 1999, ADepression: Beyond Serotonin@ by Hara Estroff Marano.)

The left side of the prefrontal cortex is thought to be involved with establishing and maintaining positive feelings while the right side is associated with negative feelings. Thus, a person with an active left prefrontal cortex may tend to be extroverted while someone with an active right prefrontal cortex may be more inclined toward anxiety and inhibition. The left prefrontal cortex also serves to inhibit the negative emotions generated by the amygdala. The amygdala appears to scan incoming experience for emotional significance, alert us to any perceived threat and decide how firmly a negative event is remembered. This is a major part of our built-in survival system.

Studies show that those suffering from depression have decreased blood flow and metabolism in the left prefrontal cortex. This is associated with difficulty in maintaining those positive feelings which motivate us to work toward our objectives; e.g., to not give up when struggling to achieve your goal. Also, as the left side of the prefrontal cortex fails to fully activate, it no longer serves to inhibit the activity of the amygdala leading to unchecked feelings of dread, fear, helplessness and negativity. Other studies show a link between a high left prefrontal cortex activity and low levels of cortisol, a stress-related hormone; thereby, suggesting that stress plays a role.

Some depressed individuals have a smaller portion of the left prefrontal cortex known as the subgenual prefrontal cortex. This brain site is connected to the hypothalamus, a deep brain structure that plays a vital role in the body=s stress response. The smaller area may be related to there being fewer glia rather than fewer neurons (brain cells). Glia, among other important duties, nourish neurons by assuring a steady supply of glucose and, also, protect neurons by stabilizing levels of glutamate. Glutamate is a major neurotransmitter that activates neurons; however, too much glutamate over stimulates causing neural damage and communication breakdown. In other words, a smaller subgenual prefrontal cortex with fewer glia may result in too much glutamate which triggers overstimulation of neurons leading to neurological damage and impairment.

Anti-depressant medications which have been thought to raise the level of serotonin appear to reduce the sensitivity of prefrontal cortex receptors to glutamate, thereby, compensating for the loss of glia cells (which stabilize the levels of glutamate so as to prevent neural damage).The point is that as our understanding of the causes of affective disorders keeps expanding we are ever reminded that these are very complex illnesses that are not yet fully understood.

Scientists now know that the brain has a capacity to change and adapt by developing new neural pathways through the sprouting of new nerve cell connections (Adendritic spines@). Neural pathways are the communication highways between other neural pathways and various brain areas of the brain. All of our thoughts, emotions and actions involve activity of these neural pathways. The development of new neural pathways is called Aneuronal plasticity@.

The depressed may also have a deficit in those substances which lead to specific nerve growth;

i.e., the creation of new dendritic spines. For example, the Abrain-derived neurotrophic factor@ strengthens the connections in the hippocampus (a center of learning and memory) and enhances the growth of neurons that respond to serotonin. A deficit of this substance reduces neuronal plasticity in a way that decreases the number of serotonin responding neurons which may create symptoms of depression in some people.

Certain antidepressants increase the level of serotonin through a process known as selective serotonin re-uptake inhibition. They may also act to increase a neuron=s production of brain-derived neurotrophic factor; thereby, promoting the development of new neural connections in the area of the brain that has been linked to depression (i.e., the hippocampus) which neural connections are more responsive to serotonin.

Other studies are beginning to reveal the link between stress and depression. Stress decreases the level of brain-derived neurotrophic factor resulting in reduced neuronal plasticity. Furthermore, research indicates that prolonged stress causes hippocampus cells to atrophy and retract their dendrites. This results in declining cognitive functioning, one of the symptoms of depression. New research is studying the role early living experiences play in neuronal plasticity throughout a person=s life. Stress or trauma early in life may permanently sensitize neurons and receptors throughout the central nervous system so that they perpetually over respond to stress.

Stress is a subjective perception of a threat to your physical or psychological well-being. Stressful events cause the hypothalamus to step up production of corticotropin-releasing factor which induces the pituitary gland to secrete adrenocorticotropic hormone which in turn activates the adrenal glands to produce cortisol. Early trauma can lead to chronic over activation of this system. Corticotropin-releasing factor is known to act on various brain sites to create symptoms of depression. Studies show that patients who experienced early trauma reacted to experimental stress with elevated stress hormones. Those with current major depression had the highest levels.

Returning to the Adiathesis-stress model@, some inherited factor (a flawed gene for brain-derived neurotrophic factor) and individual differences in prefrontal cortex activity may create a biological vulnerability for major depression. An early stressful experience may then set up the brain to permanently over react to environmental pressures, triggering the chemical reaction discussed above that acts on multiple sites in the brain and body to produce the behavioral symptoms of depression.

Another key factor may be “learned negativity” or “learned helplessness. Parents, some of whom may want only the best for their children, can be overly critical, corrective or protective. The child perceives him or herself as always falling short of the mark and, therefore, a failure. This type of upbringing can establish a pattern of subconscious, automatic negative thoughts and feelings which are in line with depression. See Feeling Good by David Burns, MD for a detailed discussion.

The good news is that depression is very treatable through a combination of therapy and medication. As we learn more about what causes depression, there is a greater appreciation of the value of therapy. Therapy helps the depressed patient learn how to overcome past trauma, improve their day to day coping skills, and work on their inter-personal relationships. The brain generates new neural pathways which are the result of learning positive responses to daily challenges and problems.

How can I distinguish the illness of depression from a normal emotion?

Depressive illnesses are to be distinguished from short-term states of depressed mood or unhappiness which are normal emotional reactions to a loss, or, perhaps, merely a temporary Ablue mood@. A Abad@ day will pass on its own or through your efforts to change your mood. Neurotransmitter imbalances (whatever the cause), however, do not right themselves because you wish it so or because you exert more self-determination and willpower.

Some people may be genetically predisposed to suffer from depression. For them, a depressive episode may seem to come on for no discernible reason. For others, it may come about as the result of a change in body chemistry caused by the presence of another illness, certain medications, substance abuse, hormonal fluctuations or unrelenting stress. Distressing life events such as the death of a loved one, divorce, job loss, financial setbacks, loss of a home, etc. can cause anyone to feel depressed - especially if they have not developed effective coping skills. However, if the symptoms of depression persist for more than two weeks, maintaining or increasing in intensity, this normal Areactive depression@ may have evolved into clinical depression requiring professional help.

A complete physical and mental evaluation by qualified healthcare professionals provides your best opportunity for an accurate diagnosis which is the foundation for creating an appropriate plan of treatment. Your treatment plan may require a change of a medication that is triggering your symptoms of depression, treatment for another illness that is creating symptoms of depression, or you may need therapy with or without use of anti-depressant medications.

Major depression is characterized by an extreme or prolonged episode of sadness and feelings of hopelessness in which a person loses interest or pleasure in previously enjoyed activities. Major depression interferes with a person=s critical thinking skills, ability to work, sleep, eating and sexual drive. Depressive illnesses may be mild or severe. They may reoccur.

Self-Identification Quiz for Depression

- ✓ The box ( ) for each "*yes*" answer.
  overwhelming sadness, feeling empty
  losing interest in hobbies or other pleasurable activities
  withdrawing from family and friends
  dwelling negatively on the past
  have negative thoughts and urges
  crying easily or you want to cry but cannot
  over reacting - emotional response is out of proportion to the stimulus
  under reacting - emotional response is flat to a serious event
  changed eating habits - unusual weight gain or weight loss
  have difficulty falling and staying asleep
  awaken in the early morning and cannot fall back asleep
  cannot seem to get enough sleep - loss of energy and stamina
  feeling restless, irritable, anxious
  feeling helpless and/or hopeless
  feeling despair, worthless, ashamed
  have difficulty in thinking, concentrating, and making decisions
  slowed movement
  think about death and maybe even taking your own life (***seek assistance immediately)***

If even a few of the above symptoms persist regularly over a two week period, an evaluation by a qualified healthcare professional should be sought.

Bipolar Disorder (Manic-Depression)

Bi-polar disorder (a/k/a manic depression) is characterized by alternating cycles of elation or mania (highs) and depression (lows). Usually these mood swings are gradual; however, some people suffer very rapid cycling. In addition to the symptoms of depression, bi-polar suffers may display the following signs of mania:

- ✓ The box ( ) for each "*yes*" answer.
  heightened mood, exaggerated optimism and self confidence
  decreased need for sleep without experiencing fatigue
  have grandiose delusions and inflated sense of self importance
  are excessively irritable
  increased mental and physical activity
  racing speech, flight of ideas, impulsiveness
  use poor judgment, easily distracted
  engage in reckless behavior - spending sprees, rash business decisions, erratic driving, sexual indiscretions, risky relationships, etc.

If even a few of the above symptoms persist regularly over a two week period, an evaluation by a qualified healthcare professional should be sought.

What is psychotherapy?

Psychotherapy treats the person behind the illness. In less serious situations, the therapist may first try short term counseling (10 to 20 weeks) without medication. Sometimes, anti-depressants are used to quickly lift an individual out of a serious depression, thereby allowing therapy to work more effectively. Also, there are cases of major depression where there exists a serious health risk or the person is suicidal and hospitalization may be required.

Generally speaking, there are three types of psychotherapy: behavioral therapy which concentrates on current behaviors, cognitive therapy which focuses on thoughts and beliefs, and interpersonal therapy which involves current relationships. Cognitive and behavioral therapy helps the person to recognize and change negative styles of thinking and behavior that may contribute to depression. This therapy can teach a person better coping skills, thereby, changing our reactions to and reducing the harmful effects of stressful situations. Interpersonal therapy looks at how one can work and live with other people more effectively. It seeks to change those Atoxic@ relationships that can trigger or worsen an episode of depression.

Sometimes the therapy is personal - just the person and his or her therapist. Other times it involves a group of people who openly and frankly discuss their problems and experiences with others under the guidance of a professional facilitator. To learn more about depression, therapy or medications, LCL sponsors a Alawyers= only@ open forum in Philadelphia. Lawyers and judges can attend this free meeting which is held monthly in the offices of a local psychiatrist.

A good therapist can help a person to understand how depression has tainted their self-perception and come to understand how others may view you. Because most people don=t understand the symptoms of depression, they may see someone suffering from mood changes as untrustworthy or insincere, or, if they cry easily or seem overanxious are merely weak, or, the anxious and irritable are labeled as Aalways in a bad mood@ and are to be avoided. Therapy helps a person to gain insight on how and why others react to their outer symptoms of depression. This understanding combined with learning to modify those thoughts and habits that contribute to stress, anxiety and depression are fundamental to recovery and happiness.

What are anti-depressants and mood stabilizers?

As discussed above, scientists have believed that anti-depressant medications work by re-re-balancing the neurotransmitters serotonin and norepinephrine. One neuron communicates its Amessage@ to a second neuron by releasing its neurotransmitters into the synaptic gap which borders the second neuron. If the transmitter is received by the second neuron, the message is communicated. The second neuron then releases the transmitter back into the gap where the first neuron takes it back (Areuptake@) or it is destroyed by the enzyme monoamine

oxidase. The more neurotransmitters available in the synaptic gap, the more chances the second neuron has of receiving the Amessage@. Low serotonin levels could be changed by slowing down the process by which serotonin is reabsorbed by the transmitting neuron (hence, the use of Aselective serotonin reuptake inhibitors@) or by slowing down the process by which it is metabolized by the enzyme monoamine oxidase (AMAO inhibitors@).

Newer research indicates these medications may also work by reducing the sensitivity of receptors in the prefrontal cortex for glutamate, thereby compensating for the loss of glia cells (one duty of glia being to stabilize the level of glutamate so as to avoid over stimulation resulting in neural damage). More research will reveal the hidden secrets of the brain and the causes of depression; thereby, yielding more and better medications. Nevertheless, there have been rapid advances in the pharmacological treatment of depressive illnesses over the past forty years.

Let me stress that these medications neither cure depression nor automatically clear up negative self-perceptions, attitudes or behaviors. That is why therapy is always suggested even when the medication appears to lift the most severe symptoms of depression. Also, anti-depressants (e.g., first and second generation cyclics, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors and serotonin noradrenergic reuptake inhibitors) are not prone to abuse or addiction. They do not trigger the euphoric highs of alcohol or other similar drugs (prescription or illicit). This is very important for those who are suffering from both depression and alcoholism (or other forms of drug addiction). They can safely take these antidepressants without fear of triggering their addiction. Also, by properly treating their depression, they improve their chances of a successful recovery from their chemical dependency.

The Food and Drug Administration has approved several drugs to treat depression. The earliest drugs were the Atricyclics@ (Tofranil, Elavil, Norpramin, Aventyl, Pamelor) and the monoamine oxidase inhibitors (Parnate, Nardil). These drugs still work and are relatively inexpensive; however, they often carried serious side effects for some people. Ongoing research yielded a second generation of anti-depressants - the more expensive selective serotonin reuptake inhibitors (Prozac, Zoloft, Paxil); and a newer generation of selective serotonin noradrenergic reuptake inhibitors (Effexor, Serzone). Ongoing research continues to yield additional medications for those suffering from depression. Also, there are the Aolder@ monoamine oxidase inhibitors such as Parnate and Nardil which work better for some people.

Bi-polar sufferers are often treated with the same anti-depressants to combat depression but face a very limited choice of FDA approved medications for treating the manic phase. Lithium is used to calm mania and reduce suicide but its side effects may not be well tolerated. Anticonvulsants may be used when Librium is not acceptable. There is a very real concern that in treating the depression of a bi-polar sufferer, the medication may trigger a manic episode. Certain medications are less likely to do trigger a new depressive episode (e.g., bupropion a/k/a Wellbutrin) particularly when used in combination with a mood stabilizer or anti-

anti-convulsant.

Caution: when insomnia and anxiety appear as symptoms of depression or as medication side effects, sedative/hypnotics may be prescribed. Those classified as benzodiazepines (e.g., Ativan) can be addictive. If a person has a personal or family history of alcohol or other drug abuse or addiction, they should request their doctor to use non-benzodiazepine medication to assist with insomnia.

Anti-depressants are not Ahappy pills@. They help relieve depression in those that are depressed but do not elevate the mood of those who are not depressed. Anti-depressants take effect over several weeks; they do not produce instant highs or elevations of mood such as those produced by amphetamines or benzodiazepines. It usually takes several weeks of full dosage to determine if a particular anti-depressant is effective. If the person remains depressed or becomes depressed again, a new medication may be necessary. Generally, 2/3 of depressed people will respond to any given anti-depressant; however, those who do not respond to the first anti-depressant have an excellent chance of responding to another.

The gradual lifting of the depression, not a feeling of euphoria, indicates that the medication is working. The normal range and functioning of the emotions return. Life=s circumstances will bring feelings of happiness or sadness; anti-depressants will neither create nor prevent these emotions. Again, let us not forget the value of combining these medications with therapy to assist in identifying and changing those attitudes, beliefs and behaviors that may make someone more vulnerable to depression.

There are side effects to these medications ranging from dry mouth, constipation, weakness-fatigue, headaches, sleepiness or insomnia, lower blood pressure, higher blood pressure, decreased sex drive, etc. Each type of medication may act on any individual in one or more of the above ways to a lesser or greater degree. The prescribing physician can help choose a medication that may be less disruptive to an individual but sometimes it becomes a matter of weighing the overall benefit of lifting the depression against the negatives of these side effects.

How can you help someone who is depressed?

The most important thing you can do for someone who may be depressed is to help them get in touch with a qualified healthcare professional who can make a proper diagnosis. LCL=s Helpline will help you find those professionals and will even pay for the evaluation. (LCL=s Helpline services are available to judges, district justices, lawyers and their family members.) A person suffering from depression may be unable to make the call to LCL or, afterwards, to call the healthcare professional to schedule an appointment. You may need to assist the person in making these calls and, possibly, in taking them to the evaluation. Depression all too often prevents the individual from being able to help him or herself.

The second most important thing to do is to offer emotional support by listening and offering encouragement and affection. Engage them in conversation and listen carefully. Do not put down their expressions of how they are feeling, do not criticize and do not tell them what they must do. Point out the realities of the situation, with kindness, and offer hope. Take any remarks about suicide, however expressed, seriously. This is discussed in more detail below.

Try to involve them in activity such as walking, going to the movies or other outings. Be gently insistent if your invitation is refused but don=t push. Respect the fact that they can become overwhelmed if they try to do too much too soon. Help provide diversion and company but keep in mind that too many demands can increase feelings of failure. Recovery takes time; they are not being lazy nor are they faking illness. Depression is real. Be patient and supportive.

How can I help myself to get through depression?

Medication and therapy provide the foundation for long term recovery from depression. But what can you do to get through each day until the worst of the depression is lifted? The following is a list of things that have worked for many individuals. Each of us is different, so keep trying them until you find the ones that work for you.

- Keep a daily journal of what is going on and how you feel.
- Listen to music that you find upbeat and positive.
- Read anything and everything - fiction, non-fiction, books on depression.
- Get plenty of rest - don=t over exert or push yourself.
- Eat regularly and properly.
- Play on the computer.
- Rent a funny movie.
- Go for long walks - first thing in the morning if possible.
- Invite a friend over for dinner or to watch the video you just rented.
- If on medication, don=t quit taking it without your doctor=s permission.
- Do something nice for someone.
- Do something nice for yourself - buy yourself a gift or some flowers.
- Sing, whistle, hum or go dancing.
- Pick a small, easy task at home and do it: sweeping, washing clothes, picking weeds, etc.
- Read some comforting affirmations or other literature; find some quiet time to reflect upon what you have read or to meditate and pray.
- Make a gratitude list.
- Attend support group meetings. Try to help others who are depressed.
- Avoid alcohol and other similar drugs - when in doubt, ask your doctor.
- Don=t set high, unrealistic expectations for yourself or get in a hurry with your recovery - depression requires time and patience to work through.

- Avoid making any major life decisions.
- Talk things out with an understanding friend or family member.
- Try to establish a daily routine - when to go to bed and get up, meals, mild exercise or walking, taking medications. Our bodies like schedules.
- If anxious or troubled about something, ask for help. You don=t have to do this alone. In fact, letting someone help you is good for them, too.
- Go to church or temple. Volunteer but don=t over commit.
- Do not forget - depression is an illness not a personal or moral failing.

You may also wish to read the book Wellness Recovery Action Plan by Mary Ellen Copeland, Ph.D. This book shows you how to step by step develop your own comprehensive plan to address current or future bouts of depression, bipolar disorder or other illnesses. See www.WRAParoundtheworld.com

Why would anyone consider suicide?

For most of us this is a difficult and uncomfortable subject to talk about. We hope it will never happen to anyone we know or love, but the fact is that some people are driven to such despair that they take their own lives.

Take, for instance, a lawyer whose problems with depression or addiction or gambling has led him or her to Aborrow@ from escrow to pay bills, buy drugs or place a bet and is now unable to pay it back. He or she may feel a level of shame, despair and hopelessness that suicide looks like the only way out - insurance proceeds will take care of the family and their death will allow them to avoid criminal, disciplinary or other legal proceedings. It may sound unthinkable to us, but to the severely impaired attorney it can make perfect sense.

Sometimes, it is just the weariness of suffering from a chronic illness - the loss of hope that it will ever get better combined with a strong feeling of unworthiness and helplessness that leads to thoughts of suicide or death. A person may not admit to thinking about committing suicide and will even deny it, but careful listening may reveal that they have thoughts about being killed in a car crash or some other accident.

Those at higher risk for suicide include people who are suffering from serious physical or mental illness (including untreated depression); are abusing alcohol or other drugs or suffer from chemical dependency; are experiencing a major loss, such as the death of a loved one, unemployment, divorce or major financial setbacks; are experiencing other major changes in their life (e.g., retirement); and those who have made previous suicide threats.

The key to understanding why a person would take their own life lies in their feelings about their present circumstances and not the circumstances themselves. Where we may see a solution to a problem (although it may take a lot of effort and patience before the end is in

sight), they see only hopelessness. They suffer from an extreme sense of helplessness and desperation. To them, life is unbearable. They cannot see a way out.

Nevertheless, someone who is talking about committing suicide or has made an attempt may not necessarily want to die. They may be reaching out for help. Sometimes a suicide attempt becomes the turning around point in a person=s life; provided, however, there is enough support to help him or her take the action required to make the necessary changes in their life. The starting point is a proper evaluation leading to an accurate diagnosis and development of a treatment plan. Treatment may include a combination of medication and therapy as discussed above.

What are the warning signals of suicide?

If you recognize some of the following in a colleague or family member, be alert to the fact that they may need help:

repeated expressions of hopelessness, helplessness or despair
out-of-character behavior; e.g, recklessness in someone who is normally careful
changes in appearance, personality, mood, etc.
symptoms of depression - sleeplessness, social withdrawal or isolation, loss of appetite, loss of interest in usual activities (see full list), feelings of hopelessness, unworthiness…
a sudden and unexpected change to a cheerful attitude as if the weight of the world has been lifted from him or her
giving away prized possessions to friends and family
making a will or preparations for death, buying life insurance, disclosing final wishes
making remarks about death or dying
changes in medication
early onset of the medication lifting the person out of the depression

Any expressed intent to commit suicide should always be taken very seriously.

How can I help someone who may be suicidal?

The simple answer is to take action. Talk to the person directly, in person if possible. Talking about suicide decreases the likelihood that a person will act on his or her feelings. There is almost no risk that raising the topic with someone who is not considering suicide will prompt him or her to do it. Find a safe place to meet with them. Act calm. Tell him/her of your general concern for his/her well-being and offer assurances of your respect for his/her privacy - but avoid promising that you will not take the action that may be needed to save a life. Encourage the person to open up with you, then, listen attentively and without judgment. Give your full attention and let him or her take as much time as they need.

Ask about recent events; encourage him or her to talk about his/her feelings; and above all, do not minimize how he or she is feeling. Inquire if he or she is feeling desperate enough to consider ending his or her life. If the answer is "yes@, ask if there is a plan and, if so, how and where they intend to implement it. Admit your concern and fear for his or her safety. Do not react by telling the person that he/she should not be having these thoughts or that things cannot be that bad. This person's feelings are very real to him or her. We cannot discount or minimize these feelings. It is worth repeating - give the person your full attention and let him/her take as much time as they need to talk. Be patient. Let your sincerity come through. Ask if there is something you can do.

Talk to the manor woman (not down to him or her) about resources that are available for support, practical assistance, counseling or treatment (e.g., friends, family, community agencies, local crisis center). Help him or her to make a plan for the next few hours or days. Also, be available to help him/her to carry out their plan or find someone who can be available; for example, make phone calls to schedule an evaluation or session with his or her therapist. If necessary, go with the person to ensure he/she follows through with the appointment. Be helpful but allow him or her to have a sense of control.

Let the person know when you can be available, and then be sure you are available at those times. Be clear about your limits. Be realistic about how much time and emotional energy you can offer. If possible, involve others who can assist in being available and supportive. Try to have someone available at any time of day or night in case of an emergency. You will need to ask if there is anyone else who knows about his or her suicidal feelings and who would be supportive. Ask if there is anyone who should know about what is going on. Is your friend willing to tell these other people? If not, will failure to disclose put him or her in danger? If so, you may have to breach a confidence to save a life. Confidentiality is important - but secrets cannot be kept if a life is clearly in danger.

Even after the person has followed up in getting help and seems to be making progress, stay in touch to see how he or she is doing. Offer appropriate praise for having the courage to trust you and for continuing to live and struggle through the pain.

Also, a person who has been suicidal may be at greater risk after seeking help as the combination of therapy and medication may enable the individual to carry through with plans that previously he or she was too depressed to act upon. Keep in touch with the person daily and do not hesitate to address any concerns you have regarding their intentions to harm him or herself.

How can I deal with my own thoughts of suicide?

Let someone help. Don=t let fear, shame or embarrassment prevent you from asking for help. You are not alone in how you are feeling. Many people, in times of crisis or illness, have thoughts of suicide. Know that there are people who care about you and want to help you to get through these tough times. With help, the sense of desperation and the wish to die will eventually pass. It takes time, but that is where others can help you - you don=t have to be alone anymore.

Some things you can do:

- ✓ Call a crisis hotline or the emergency room of a hospital.
- ✓ Call upon friends or family members for support.
- ✓ Talk to your doctor; make an appointment with a counselor or therapist, or, increase the number of appointments with an existing counselor.
- ✓ Recognize and celebrate small improvements.
- ✓ Get involved with self-help groups.
- ✓ Talk every day to at least one person you trust about how you are feeling.
- ✓ Talk to someone who has Abeen there@ about what it was like for them.
- ✓ Avoid making any major decisions - ones you might later regret.

Conclusion

Depression and bipolar disorder are treatable illnesses. Recovery is possible. A life of happiness and usefulness can be found. If you or someone you care about is struggling with a depressive illness, seek help. Call the Confidential Helpline. Don’t delay. There is no need to wait. Help can be found now.