SIGNS AND SYMPTOMS OF DEPRESSION
Heather Fiske

Physical	Sleep disturbance
	Change in appetite, Eating
	Lack of energy, Fatigue
	Loss of sexual desire
	Digestive problems
	Pain
Emotional	Sadness
	Shame, Worthlessness
	Irrational Guilt
	Irritability, Resentment
	Anhedonia (lack of pleasure/interest)
	Helplessness/hopelessness
	Pain
Cognitive (often lead to school or work problems)	Concentration difficulties
	Memory problems
	Indecisiveness
	Suicidal ideation
	Lack of interest
	Pessimism, negativity
Behavioural	Withdrawal
	Crying spells or "flat" responses
	Slowing or restlessness
	Neglect of responsibilities
	Neglect of personal care
	Reduced coping
	Complaints
	Substance abuse

Living with a Suicidal Person

What Families Can Do

Five Hills Health Region

Written by Heather Fiske
Toronto ON
Updated in RPIW #56, Nov 2016
NF251

This article is intended as a handout for anyone living with or caring for a suicidal person.

Suicidal thinking or behaviour in a family member is one of the most difficult realities that any individual can face. It is hard to see a loved one in pain under any circumstances. It can be intolerable to see that person in such pain and distress that suicide seems like an option. It takes love and courage for people in this painful situation to seek help for their family member and themselves, to learn what to look for and how to intervene - or just to read an article like this one.

Family members in this situation sometimes feel so overwhelmed, and so afraid of doing or saying the wrong thing, that they are paralyzed. They may feel that if their relationships with the person at risk and their efforts to have a good family life haven't prevented things from getting this bad, then there is nothing they can do. These reactions are common and understandable, but misinformed. More importantly, such views may interfere with the many important things that caring relatives *can* do to help, protect and support the suicidal person. Further, the understanding provided by family members can be a key factor in making professional interventions effective. The most helpful situations are those where families and helping professionals work in partnership.

So, what can family members do?

CONCLUSION

Anything we can do that relieves pain or supports reasons for living is helpful in reducing the risk of suicide. Both the sources of pain and the reasons people find to continue living in spite of it are highly individual. Those who know and love troubled people best, their families, are in an excellent position to assist with these efforts.

Watch: How to Help Someone who is Suicidal
https://www.youtube.com/watch?v=NDp8MBVrDb4

If you are interested in learning more about mental illness and how to support yourself and your family, we offer a 10-week Family Education and Support Workshop twice a year. You can get more information from Intake by calling 306-691-6464.

Self Help Info: www.heretohelp.bc.ca

Five Hills Health Region
Healthy People – Healthy Communities

Mental Health & Addictions Services
55 Diefenbaker Dr
Moose Jaw SK S6J 0C2
Phone: 306-691-6464
Toll Free: 1-877-564-0543

Model self-care. Even when there is conflict in families, close relatives are a primary source of information about how to deal with life and problems. (One everyday demonstration of this is the kind of advice that young people give their friends—often modeled on what their parents say to them). Much more effective than telling our family members what they should do to be healthier and happier is *showing* them healthy ways of living and coping through their own actions.

An important first step is to acknowledge one's own emotional responses. Normal reactions family members may have to suicidal behaviour in a loved one include guilt, fear, resentment, anger, denial, panic, relief, sympathy, grief, frustration, confusion, disbelief, impatience, shame, hopelessness…..and the list goes on.

A second step is to model appropriate help-seeking: by having people we confide in, by relying on supportive relationships, and by using professional help when it can make a difference. Positive attitudes about getting help are instructive, especially for those who fear that going for help means that they are weak, bad, or hopelessly sick. Family members can present a constructive alternative to these fears by saying and demonstrating that getting help when it is needed is positive, strong, responsible behaviour, and that treatment can help people feel and function better and give them new skills for coping well.

Other aspects of modeling self-care may include lifestyle changes to reduce stress and improve general health; learning to live "one day at a time"; relying on strengths; and developing one's capacity to notice and celebrate small improvements.

Three Basic Guidelines

I. ASK. Ask the person about suicidal thoughts and plans. Contrary to popular myth, asking will *not* "get them thinking about it". In fact, everything we know from research and practice suggests that asking will slightly reduce the risk - and it is an essential first step toward getting necessary help. Ask for information, as well, wherever you can: information about risk factors, about available helping resources, and about how people recover.

II. GET HELP. Often, especially after a crisis has passed, the first inclination is to "put it all behind us and move on". This is a healthy and positive impulse. However, steps must be taken to make "moving on" both possible and safe. Most people who die by suicide suffer from mental illnesses such as depression, which can be effectively treated. Family members can play a crucial role in getting their loved ones the help that they need. And family members should get help for themselves also: the stress of caring for a suicidal person takes a serious toll.

III. DO WHAT YOU CAN DO. This apparently simple principle goes to the core of the dilemma inherent in preventing suicide. On one hand, we must understand and accept that suicide happens, sometimes despite our very good efforts; and on the other hand, we must remember that most suicide can be prevented, and intervene with energy and optimism. Helping a suicidal person does not mean doing everything, or doing the perfect thing: it means doing what we can. This may mean staying with the person 24 hours a day; it may mean sending a postcard once a week; it may mean working overtime to pay for treatment; it may mean brewing a cup of tea.

Helpful Practices

I. When You Are Concerned

Use the word "suicide". Using the word, and trying to be matter-of-fact about it, conveys the message that we are willing to listen and help even if things are that bad.

Don't be afraid to ask "Has it been so bad you have thought about suicide?"

Respect their pain. Acknowledging how much the person is hurting is a first step toward communication. Trying to minimize ("It's not that bad") or to argue them out of their pain ("You don't really mean that. Look how much you have to live for") may alienate and convince the person that you cannot understand.

Offer comfort. It is easy to feel that simple comforts - a touch, a kind word, home-cooked food, favourite photographs or blankets - might be helpful in a less serious situation but are inadequate in the face of a suicidal crisis. In fact, anything that makes even a small difference can help. Because suicidal people are often not thinking very clearly and may be very negatively focused, concrete reminders of positive connections and experiences are strongly recommended.

When we ask individuals who have been acutely suicidal what helped them to carry on, their most common answers are small, apparently "trivial" words or gestures of warmth and connection from other people—or even from pets.

Just be there. "They were there for me" is the tribute we make to those who have helped us to get through the dark times in our lives. It does not take a professional to provide this kind of loyal support.

V. For Your Well-being and Theirs

Maintain healthy routines. In order to be able to help and support a loved one who is at risk for suicide, it is essential that family members get regular rest, exercise, healthy nutrition, and positive social activity. Maintaining these routines also means that they are available for the person at risk to participate in when he or she is ready.

Look for signs of progress, change, and hope. Just as it is important to be aware of warning signs and be prepared to act, it is important that family members be oriented to positive change and be prepared to reinforce and celebrate such changes. Like warning signs, signs of progress are highly individual. Some examples include:

- Crying or saying "I feel sad", especially in an individual who has kept pain hidden in the past
- Being obnoxious, in the case of a depressed teen who has been withdrawn and listless
- Asking for help
- Making future plans
- Showing pleasure or enjoyment
- Recovery in sleep, eating, or energy
- Development of new pain management or stress coping skills (a positive alternative to "SOS" - "suicide as the only solution")

Often, family members notice the first small signs of progress before the individual is aware of the changes.

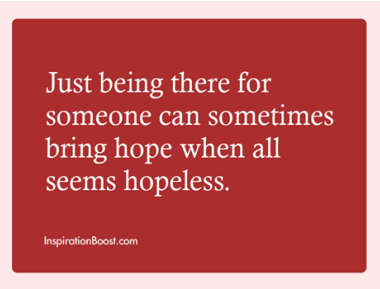
IV. To Make a Healing Difference

Support people's reasons for living. Anything one person does to recognize, reinforce, or support another person's reasons for living is suicide prevention. Family members are often uniquely qualified to understand what may be most important, salient, and relevant for the suicidal person, and may be most likely to divert attention or interest away from death as a solution.

Communicate a sense of belonging. Psychologist Thomas Joiner has identified "thwarted belonging" - the belief that they do not and cannot fit in anywhere - as one of the key perceptions held by individuals who are in imminent danger of suicide. Family members can say and do many things to counter this view and to communicate a sense of inclusion.

Communicate that the person is valued and valuable. A second view identified by Joiner is "perceived burdensomeness"—the idea that "they'll be better off without me" which is a common theme of suicide notes. Family members can contradict this belief both directly (in words) and indirectly (by showing and telling the person how they are valued).

Identify risk factors and warning signs. In the vast majority of cases, diagnosable *and treatable* **mental illnesses** such as depression contribute to suicidal thoughts and behaviours. Depression is very common but often unrecognized, especially when the most noticeable symptoms are irritation and hostility (especially common among young males) or increased complaints about physical aches and pains (especially common in the elderly), rather than the sadness and crying we more typically expect. Both counseling and medication are effective treatments for depression.



Depression has been shown to have a basis in brain chemistry, which is one of the reasons that medication is often recommended as part of treatment. Fears and misunderstandings about antidepressant medication are widespread, and so it is especially helpful if family members are able to:

- get good information about the medication and its effects;
- work closely with both their at-risk family member and the prescribing doctor;
- help to ensure that medication is taken as prescribed; and
- if the medication is not helpful, check with the physician to see, first, whether a change in dosage, timing or drug choice might work better; and second, if stopping the medication, how to do it safely.

Regular exercise has also been shown to be an effective treatment for depression and other mental illnesses. Family members can play an important role in helping a depressed person to "get moving".

Other illnesses and conditions that can contribute to suicide risk include bipolar disorder (manic-depressive illness), conduct disorder, borderline personality disorder, severe anxiety, learning disabilities and of course substance abuse (including problem gambling). "Dual diagnosis" (more than one illness) creates greatly increased risk. In particular, the combination of substance abuse with any other condition is a very high-risk situation.

The risk category of "**stressful or painful life events**" includes a long list of experiences that contribute to suicide risk, including: relationship loss, adjustment factors (e.g. to physical illness or disability, or sexual/gender identity issues), performance failure; and family factors (such as stress, illness, conflict, abuse or violence, or substance use problems within the family).

It is useful to remember that almost always there has been an accumulation of stressors, usually in the context of depression or other illness, rather than a single "event" which causes a suicide plan or attempt. While there may be no single "solution", intervening with any of the difficulties that have contributed to the person's pain and distress can help to reduce the risk of suicide.

For example, school failure associated with learning problems or depression may be a factor for one suicidal teenager. If so, working with the school to get appropriate extra help or tutoring, or educating teachers about what the child is going through, may make a difference.

- Physicians
- Hospitals
- Crisis or distress centers
- Mental health clinics
- Mental health professionals, e.g. psychiatrists, psychologists, social workers, psychotherapists (employed persons *and their immediate family members* may have coverage for these services through insurance or employee assistance plans).
- Family and friends
- Clergy: many have training in counseling and most will be able to make suggestions about other resources as well as offering support
- Self-help programs
- For young people, school- or college/university-based helpers (psychologists, social workers, counselors, etc.)

Suicidal people may be easily discouraged in help-seeking, especially if there are delays or complications. Family members can be of great assistance in actively pursuing treatment. One of the most common difficulties is waiting lists. I recommend that families (a) get on the list! - the appointment can be cancelled if something turns up earlier; (b) continue to look for alternatives in the meantime; and (c) call regularly to inquire where they are on the list and to remind the service provider that they are eager to be seen and (if possible) willing to come on short notice if an opening occurs. There are no guarantees, but "squeaky wheels get grease".

DON'Ts

Don't panic

Don't ignore the signals

Don't promise secrecy

Don't leave the person alone

Don't debate the morality of suicide

Don't tell the person to be grateful for what they have

Don't say that everything will be all right

Don't challenge the person to go ahead

Don't do nothing.

The essentials in a suicidal crisis are to keep the person safe, to respond (do something!) and to get help. Remember: often a crisis is the beginning of helpful intervention and change.

Suicide Crisis Line 306-525-5333
Healthline 811

Connect with local resources and advocate for treatment. Helpful treatment is widely available but not always readily accessible. Any of the following resources may be able to provide (a) direct help or (b) referrals to appropriate agencies and professionals:

As noted above, some of the risk factors involve family issues. The "good news" about recognizing that family factors may be involved is this: If family members are able to take steps to deal with any of their own problems, their actions can make a difference in the suicidal individual's level of risk. And of course, seeing a family member getting help is an excellent example for a troubled person.

A last major category, **environmental risk factors**, primarily concerns the availability of the means or methods of suicide in the person's surroundings. Block the exit! Remove guns, pills and other poisons, ropes, knives, car keys - anything that you know or suspect could be used for self-harm.

Pain Isn't Always Obvious

KNOW THE SIGNS

Suicide Is Preventable

Warning signs of imminent danger for suicidal behaviour may be direct and obvious, like saying "I am going to kill myself today", or more subtle and hidden. Once the suicide issue is out in the open, often as the result of a crisis, families have the opportunity to consider the person's recent behaviour in a new light and to understand individual warning signs

Common signs include:

- *preoccupation with death*
- *self-destructive behaviour* of any kind
- signs of *depression* (see attached list)
- *changes* (including increases, decreases, and differences) in :
  - ⇒ behaviour
  - ⇒ motivation
  - ⇒ appearance
  - ⇒ mood
  - ⇒ emotions
  - ⇒ physical state
  - ⇒ (Because the changes vary so much among individuals, family members' knowledge of what is typical for the person is important).
- *hopelessness* is very strongly associated with suicidal thinking and behaviour, even in people who are not clinically depressed.
- *making final arrangements*
- *lack of interest in future plans*
- *substance abuse* (in a vulnerable person, can increase the likelihood of impulsive self-harm and remove inhibitions on suicidal behaviour).

Support suicide prevention groups and networks. Local suicide prevention groups and regional/national groups like the Irish Association of Suicidology and its Canadian or American counterparts can provide useful information, a sense of connection with a community working to reduce suicide, and, when they are ready, opportunities for people who have "been there" to make valuable contributions in volunteer work or advocacy

II. To Keep Them Safe

Learn the basic "dos and don'ts" of crisis intervention.

DOs:

Do ask about suicide

Do know the warning signs.

Do act calm. Soothing tones of voice can make a difference.

Do try to be accepting and honest.

Do give them a sense of control. To the extent that they are capable, suicidal people should be offered choices. For example, if they are able to participate in the decision to get help, this is ideal.

Do restrict access to their intended means of suicide ("block the exit"). In particular, remove firearms and poisons.

Do GET HELP. There is a range of options for getting help in a crisis, from contacting a family doctor or school counselor through various crisis- specific services (hospital emergency room, mobile crisis unit, distress line, etc.). In extreme cases where the person is unable or unwilling to cooperate, an ambulance or police can be called.