

Secondary Conditions
Preventions & Treatment:
B Series---N0.4

SCI & Depression

**The Research
and Training
Center on
Independent
Living**



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Abstract: Contrary to what some people might assume and what the medical profession once believed, a person who has a spinal cord injury is not an automatic candidate for depression. Just like other people who live with an injury or have an abrupt change in their lives, people with SCI may face depression. This may occur as a result of their injury and be referred to as a secondary condition. Depression is as treatable for a person with a spinal cord injury as for anyone else. The things that help the general population avoid or overcome depression also work for people who are paralyzed.

Whether a person has a spinal cord injury or not, depression can be caused by a number of things. The following are among the most well-known are an imbalance in the chemicals that affect the brain, illness or injury that changes the body's chemistry, and a predisposition to become depressed.

Studies do report that anywhere from 17 to 38 percent of people with spinal cord injuries meet the diagnostic criteria for major depressive conditions. When the evaluators, however, asked newly injured people if they were depressed, only 11 percent rated themselves as being depressed. One study, in fact, even reported that less than 2 percent of individuals with spinal cord injuries could be diagnosed as depressed.

The numbers suggest that major depression following injury is certainly not universal, and, as suggested, those who are injured and health professionals who are looking for signs of depression may see things differently.

Still, it cannot be ignored that many people with spinal cord injuries do experience an episode of major depression. The depression, however, does not seem to correlate with the level of injury. Various studies point to a number of reasons why someone with disability may become depressed. How much pain, overall health, and stress a person has and how soon the person returns to active living, exercise, and outside activities all seem to affect depression.

Effective treatments include antidepressants and psychotherapy. Also beneficial are a positive attitude, social relationships, exercise, good nutrition, pain control, and an active life.

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Understanding and Treating Depression

Every year, 17.6 million American adults, or 10 percent of the population, experience some type of depressive condition. Depression comes in several forms, with symptoms and severity ranging from mild to severe. Depression can occur just once for a few weeks, periodically throughout a lifetime, or for years without let up.

Contrary to what some people might assume and what the medical profession once believed, a person who has a spinal cord injury (SCI) is not an automatic candidate for depression. Just like other people who live with an injury or have an abrupt change in their lives, people with SCI may face depression. This may occur as a result of their injury and be referred to as a secondary condition. Depression is as treatable for a person with a SCI as for anyone else. The things that help the general population avoid or overcome depression also work for people who are paralyzed.

People with depression really struggle, as do the people who love them and care about them. It is not possible for someone who has depression to simply “snap out of it,” “lighten up,” or “get a life.” But that is sometimes what they hear from people who do not understand what depression is and how it makes a person feel and behave.

Anyone can get depression, for it plays no favorites based on age, gender, illness, or disability. At any one time, throughout the United States 5 to 9 percent of women and 2 to 3 percent of men are depressed. Over their lifetimes, 25 percent of women and 7 to 12 percent of men will experience depression²

Depression appears to be widespread, but the good news is that 80 percent of the people who have depression can be helped. Science does not have a cure for depression, but medications and psychotherapies used to treat depression have improved, and they do help.

In this booklet, you will learn about depression: what it is, what causes it, what forms it takes, and its symptoms. You will also learn how depression specifically concerns people with SCI. Finally, you will read about ways to avoid depression and ways to treat it.

What is depression?

Depression is the most common of all the mental illnesses in this country. It is so widespread, in fact, it has been called the common cold of mental disturbance.

The best way to define depression is to first mention what it is not. The word “depression” is not interchangeable with the word “sad.” How many times do people say, “I’m so depressed”? Most of the time those words mean someone feels down in the dumps, or the day didn’t go well, or the person is upset or tired. People may feel sad, discouraged or listless for a few days, but that doesn’t mean they have depression.

Depression is much more than a momentary “down” feeling. Depression is a whole-body condition that affects a person’s body, mind, and thoughts. Depression comes from chemical changes in the brain, and it holds on until the brain’s chemistry once again comes into balance. People who are depressed do feel sad, discouraged, and listless. But people with depression who feel this way are different from someone who simply feels sad for a few days or weeks. People are considered “clinically depressed” when the depression alters their day-to-day life and ability to function.

In addition to feeling sad, they also show many of the physical symptoms often associated with clinical depression. These symptoms include tearfulness, apathy, irritability, loss of appetite, disturbed sleep, lack of energy, or thoughts of death.

Their depression affects their ability to take care of themselves and their responsibilities. Their feelings change their behavior for a noticeable period of time. They may no longer have

their usual eating and sleeping patterns or they may sleep so much that they no longer are effective on the job or with their family members and friends.

Depression also affects how people feel about themselves and how they see the world. A person who has depression most likely feels worthless. He or she sees the future as hopeless and feels helpless or powerless to change things. The person may want to die, and may even attempt suicide.

Some people who are not clinically depressed still may feel sad for more than just a few days. They may have what is known as “situational depression” or distress. A death in the family, loss of a job, a move to a new city, or an accident or illness may cause people to feel sad, worried, or tense. They also may feel hopeless or helpless, but they do not have the dysfunctional symptoms associated with clinical depression.

Too often people with SCI are diagnosed as having depression, when really they are facing natural feelings of distress. Their life changed significantly after their injury. It is not surprising that people with a recent SCI may feel anxious, tense, fearful, and sad, even moody. But they are not automatically clinically depressed.

What causes depression?

For people with SCI, depression falls among the secondary conditions that can occur after an injury. Like joint problems, urinary infections, contractures or fatigue, depression may follow an injury. As with other secondary conditions, people with SCI want to know what causes this secondary condition called depression.

Whether a person has SCI or not, depression can be caused by a number of things. The following are among the most well-known:

- An imbalance in the chemicals that affect the brain
- An illness or injury that changes the body’s chemistry
- A predisposition to become depressed.

Some researchers link depression to chemical changes in the brain, while others debate the link between brain chemistry and depression. The disagreement focuses on whether the causes for depression are psychological or biological: Does depression start in the brain? Does it start because chemicals released in the body affect the brain?

Some people think life events may trigger chemical reactions in the body, for the brain is an organ that responds to its environment which is the body. When a person who is not prone to depression feels stressed, the brain sets off a release of chemicals, including hormones like adrenaline and neurotransmitters such as serotonin and dopamine. When these chemicals reach a certain level, the brain shuts off production, and the person feels better.

But in people who are prone to depression, the shut-off valve for these chemicals doesn’t work properly. So when something triggers a release of these chemicals, the brain gets more than it needs. This chemical imbalance may bring on the symptoms of depression.

Researchers have identified more than 75 neurotransmitters, so no single chemical is responsible for depression. The neurotransmitters norepinephrine and serotonin are known to be especially important in depression and its treatment.

According to the National Institutes of Health, what triggers the chemical changes and the depression is not always known. Sometimes depression strikes for no apparent reason. Some drugs, such as steroids and muscle relaxers, can cause depression. Sometimes a life crisis, such as SCI, increases a person’s stress and this stress then brings on depression.

Research shows that some depressive conditions run in families. So researchers think there might be a genetic link to some forms of depression. However, many people are depressed who

have no family history of depression, and many people never become depressed who have strong family ties to depression.

Some people seem psychologically more prone to depression. These people include those with low self-esteem, those who have a pessimistic view of the world, those who are dependent on habit-forming drugs, and those who are easily stressed and who become overwhelmed by stressful situations. Sometimes the combination of an unhappy life change and a familial or psychological tendency to depression brings on the condition.

A depression-causing illness, stress or unhappy occurrence changes the brain's chemistry, so the depression continues after the stress or illness ends. The lingering depression brings a new set of stresses. The person thinks he or she should feel better when the illness or problem goes away. A person with SCI may assume that when he or she returns home from the hospital, or goes back to work, or gets the home adapted for a wheelchair that good feelings will quickly return. When those feelings don't come back, the person's depression may deepen. The person must now cope with the stress of depression, and this stress continues to affect the brain chemistry. Sometimes years can go by before medication or therapy disrupts the cycle of stress followed by depression.

SCI and depression

Researchers Timothy Elliott and Robert Frank specialize in studying the links between depression and physical disabilities, including spinal cord injury. Depression is probably the most frequently studied psychological variable among persons with SCI, the topic, they say, has been studied to death.

But researchers aren't that much closer to understanding if and when a person with SCI is likely to have depression. In fact, some researchers think people with SCI too often have been incorrectly diagnosed as having clinical depression or that the word depression often is used with imprecision.

Some studies with those who have postpolio syndrome also show a lower rate of depression than people once assumed. Clearly there seems to be a shift in how depression among those with disabilities is being viewed and reported. The problem of inaccurate reporting may stem from one of three issues, some medical and some emotional:

1. First, SCI produces some trauma symptoms that are associated with major depression, such as loss of appetite and sleep disruption.
2. Second, many health professionals don't understand the differences between normal grief responses to a sudden injury and symptoms of depression.
3. Third, many health professionals and researchers who interact with or who study depression and SCI have a hard time sorting through their own feelings. They may project how they would feel about an injury onto the person who is injured.

Let's look at these three issues a little closer.

Trauma symptoms

Acute SCI is marked by weight loss, altered sleep patterns, and changes in appetite, energy, physical sensations and mobility. These symptoms are also among those used to diagnose major depression.

Health professionals and researchers don't know how to sort out the symptoms linked to SCI trauma from those linked to depression. Is the person in the rehabilitation unit losing weight because he is depressed or because his body is adjusting to the injury? Or both? Is the young woman in the hospital not sleeping because she is depressed or because it's hard to sleep in a

hospital? Or both? Is she irritable because she's not getting enough sleep or because she's depressed? Or both?

Some researchers have found that tracking people's negative statements and actions more than their physical symptoms may be a better way to evaluate people with SCI for depression. Is the person projecting a negative self-image? Is he or she talking about suicide? Does the person sound like he or she feels intense guilt over the accident that caused the injury? These thoughts may be more likely to signal depression among those with SCI.

Grief and feelings

Following an injury it is natural to feel anxious, distressed, restless, and even negative and unhappy. Not only are these feelings natural, they also are common. People can be mildly depressed or feel out of sorts while they adjust to their injury and the changes it brings.

A spinal cord injury may mean the end of a job a person loved but can no longer do. The injury may mean the end of activities a person enjoyed. Often the injury means the person must learn many of life's basics all over again: how to move around the house, how to resume personal care, how to go out with friends for the evening.

Losses of skills, independence and mobility initially may bring great sadness. This sadness may be a natural response that accompanies a person's period of adjustment. Are people who look unhappy during this time of transition clinically depressed or just coping with change? Do they need antidepressants if they are tearful? The answer could be yes or no. But the answer is not automatically yes.

Sometimes professionals find it hard to remember that a sad mood does not warrant a diagnosis of depression. The mood, after all, may reflect a fleeting and a natural reaction to a number of life changes related to family, job, finances and environment.

Grief is healthy. Everyone feels grief when they face the fact that something or someone is gone for good. The sadness that comes with this awareness is different than depression. Grief does not make a person feel worthless; grief does not bring long-term dysfunction; grief does not make someone plan a suicide.

Projection

So if the symptoms of SCI trauma are natural and if it's common for people to feel sad or to grieve, then why do many health professionals assume that people with SCI are depressed? The answer may have more to do with stereotypes and myths than with science.

Many clinicians, Elliott says, believe depression naturally follows an injury. They assume people mourn their condition to the point of depression. Before 1987, depression was seen as the natural psychological adjustment to a spinal injury. "To a great extent," says Elliott, "these assumptions may have been influenced by the stereotypical expectation that people with SCI are consumed with the trauma of physical disability."

Health professionals, in fact, saw depression as normal, even desirable. They argued that people who weren't depressed probably were denying their injuries, and if they denied their injuries, they would never make a proper adjustment.

Before 1987 and even today, the reality of the person's feelings and needs may still be ignored. Antidepressants may be prescribed when they aren't necessary. People with SCI who worry about finances, marital relationships, or adaptations to their living space often cannot get their concerns acknowledged. It is assumed they are depressed, when what they need is help solving their real problems.

Another study shows that people see those with a physical disability as being less happy and less satisfied with life. But responses to a questionnaire on the subject of life quality given to

those with and without a physical disability showed no difference in each groups' ratings of life satisfaction, frustration with life or mood.

The questionnaire asked: If you had one wish, would you wish to be no longer disabled? Only 49 percent said they wished to be no longer disabled. Only 11 percent of the respondents saw their disability as a terrible thing, and only 7 percent saw the disability as the worst thing to have happened to them. Most saw their disability as a fact of life and an inconvenience. But they also saw being kind, intelligent, and productive as more important than being without a disability.

These assumptions about depression and the lack of an accurate diagnosis affect people with SCI. Elliott and Frank think the presumption of depression may work against the person with SCI. Treatment and rehabilitation may be approached differently if the person is presumed to have major depression. Less may be expected of him or her; less or different things may be offered.

What helps people with SCI avoid depression?

Are people with SCI depressed? Given that almost 18 million people a year are depressed in this country, it is reasonable to assume that people with a spinal injury are among this group. It is also likely that some of those who are injured and who are depressed would have depression even if they didn't have SCI.

Studies do report that anywhere from 17 to 38 percent of people with SCI meet the diagnostic criteria for major depressive conditions. When the evaluators, however, asked newly injured people if they were depressed, only 11 percent rated themselves as being depressed. One study, in fact, even reported that less than 2 percent of SCI individuals could be diagnosed as depressed.

The numbers suggest that major depression following an SCI is certainly not universal, and, as suggested, those who are injured and health professionals who are looking for signs of depression may see things differently.



Visiting with a therapist or counselor is a good step toward treating depression.

Still, it cannot be ignored that many people with SCI do experience an episode of major depression. The depression, however, does not seem to correlate with the level of injury. Various studies point to a number of reasons why someone with SCI or other disabilities may become depressed. How much pain, overall health, and stress a person has and how soon the person returns to active living, exercise, and outside activities all seem to affect depression.

Return to an active life

A return to active living includes such things as being in control of one's care for oneself. Depending on the level of injury, a return to active living may include going to work or reestablishing social relationships. These daily activities help people avoid depression or experience only its milder forms.

Pain control

Studies show that people with SCI who have acute pain also have a much higher rate of depression. This is also true for people with postpolio syndrome. The presence of pain appears to affect depression more than the presence of depression affects pain, but researchers are still studying this pain-depression link. Some people suggest the possibility that the bodily stress brought on by pain may trigger the chemical imbalances that bring on depression. These findings underscore the importance of controlling acute pain as a way to help an injured person avoid depression.

The longer a person remains in acute pain, the more likely he or she will become depressed. It is also more likely that the pain will become chronic, and chronic pain following SCI is a good predictor of who will likely experience

People with chronic pain following SCI are likely to have trouble being employed and to have more mental distress, including depression. The longer the pain and the depression continue, the harder it will be to separate the relationship between the pain and the depression or to treat them.

Exercise

Exercise is an underused treatment in the fight against depression for those with physical disabilities. "People who don't exercise are at greater risk of depression," says James Blumenthal, professor of medical psychology at Duke University, "for some clinically depressed patients, exercise is as effective as the best medications we have."

Some studies support Blumenthal's assertion, for important links have been found between a sedentary lifestyle among people with SCI and their higher rates of depression. In one study group, those who had physical disabilities and who did aerobic exercises had a 59 percent reduction in their depressive symptoms compared with only 6 percent among those who did not exercise.

So, increasing physical activity might prevent depression or help people treat their depression once it begins.

For more information on exercise for people with SCI, see these booklets produced by the Research and Training Center on Independent Living (RTCIL) at the University of Kansas: Chronic Fatigue, Joint Problems, SCI & Aging, and Deconditioning and Weight Gain.

Outside and leisure activities

Outside and leisure activities also play an important role in treating or preventing depression. Hobbies, recreational activities, travel and going to work all seem to help people

avoid or treat depression. In fact, specifically increasing someone's activity level might be part of a good treatment program for depression.

Overall health

For those people with disabilities, there's a strong connection between depression and overall good health. In postpolio survivors, for example, those who said they were depressed also reported poorer health. Whether depression causes increased health problems or whether health problems cause depression is not always clear.

Studies do show that people who are depressed are more likely to have secondary conditions like pressure sores and urinary tract infections and poor health, in general. People who are depressed also spend more time in bed, which can make them more vulnerable to skin breakdown. One researcher found that the severity of a person's depression often was a good predictor of how successful he or she would be with bladder function and skin—care activities.

It seems likely that maintaining good personal care: eating right, preventing pressure sores, and attending to infections may also promote good mental health.

Stress

Chronic stress seems to increase the risk for depression. Many people who study the connection between SCI and depression often note that life problems more than the injury, seem to be what brings on depression. The level of stress people with SCI may feel depends in part on their personal and social resources. Did they have good coping skills before they were injured? Were family members supportive before the SCI? Did they have a strong network of friends and activities? Identifying those things that bring stress and finding ways to reduce or manage that stress helps people reduce or prevent depression.

Other factors

Other things may make a person with SCI depressed, and these things have nothing to do with the injury. The person may have:

- A genetic tendency to depression
- Poor coping skills
- Difficulty thinking about solutions to problems
- A psychological disorder such as schizophrenia
- An experience with depression before the injury
- A personality prone to depression
- Abused drugs or alcohol before the injury or after
- A combination of job, family or social problems that triggered
- Depression when the person was injured.

People who were well-adjusted before their injury tend to be people who are well-adjusted afterward. People who described themselves as having good-problem solving skills, who were reflective about life, and who had a well-developed network of friends and family are also more likely to report themselves as not being depressed after their injury.

Visiting with a therapist or counselor is a good step toward treating depression.

Types of depression

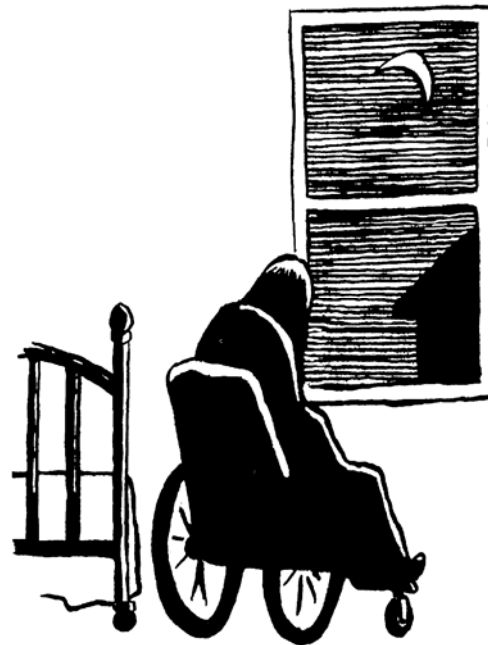
There are several types of depression, each with its own level of severity.

Major depression. A major depression is the most serious form of depression and the most disabling. A person with a major depression stops functioning effectively in his or her daily life. This form of depression can occur once, twice or several times in a person's life. Someone will be diagnosed as having a major depression if she or he has at least five of the following symptoms, if these symptoms occur over most of the day and if they continue almost every day for at least two weeks:

- Despondent mood
- Loss of interest in pleasurable things, including sex
- More than a 5 percent weight loss or gain in a month
- Decrease or increase in appetite
- Insomnia or oversleeping
- Restlessness or listlessness
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Difficulty thinking, remembering or making decisions
- Persistent ailments that don't respond to medical treatment
- Thoughts of death or suicide or suicide attempts.

But not everyone with five or more of these symptoms has major depression. A person may display these symptoms as a natural response to a death, other traumatic events, or because of a physical cause. A spinal cord injury, for example, may cause many of these symptoms during the first months following an injury, but symptoms might also be related to physical or biological results of the injury and not to depression.

The treatment for major depression is a combination of antidepressant drugs to improve the brain's



chemistry and psychotherapy to talk about what is happening in the person's life and about how to make life changes.

Dysthymia. Dysthymia is a chronic, but milder form of depression. In fact, it can be mild enough that people with this condition may not see themselves as being depressed. Dysthymia can last for two years or longer, and is often damaging because it slowly drains away a person's energy and self-esteem.

People with dysthymia may not appear to be ill. Instead they may refuse to take on new challenges, may be negative about themselves, may worry that others are displeased with them and may always feel tired. One writer described a person with dysthymia as the character

Woody Allen always plays, the pessimist who is always worried and unhappy.

Major depression and dysthymia share the same symptoms. The length and severity of the depression is what distinguishes them. Dysthymia causes milder symptoms, but it lasts longer. A danger of suicide is not usually a factor. Dysthymia can, however, turn into a major depression episode.

Dysthymia is often underdiagnosed. In fact, the American Psychiatric Association didn't even consider it a depressive condition until 1980. More often people with dysthymia are seen as troublesome or difficult to deal with. Friends and family might describe them as people who lack spunk, who are undermotivated or who just seem to be going through the motions of life without becoming too involved.

People may have dysthymia if they have two of the following symptoms, if these symptoms last throughout most of the day, if the symptoms continue for more than two months, and if the person is not known to have a mental illness like schizophrenia or manic-depression:

- Despondent mood, possibly with irritability
- Poor appetite or overeating
- Pronounced changes in sleep patterns
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Hopelessness.
- Antidepressants and psychotherapy can help.
- Situational depression

A situational depression occurs when a specific situation such as a death, illness, injury, or job loss brings on a short-term depression. The depression starts within three months of the occurrence and lasts no longer than six months.

The person may temporarily not perform well at work or school, may avoid social activities, and may be withdrawn or irritable at home. With time the depressed mood fades away and the person learns to cope with whatever happened. Some mental health professionals think situational depression is a typical and even a desirable response that helps the person deal with a loss and accept it. If the situational depression lingers for a long time, however, it can develop into major depression.

Treatment

In most cases of depression the brain's chemical imbalance eventually will correct itself, but often this correction takes one to three years. Most people cannot and should not wait this long to feel better. Given the high rate of completed suicides among those who are depressed, it is safe to say that putting off treatment

The first step in getting the right treatment is to get a complete physical from a health care professional who is familiar with SCI. Other medications or physical conditions may cause symptoms similar to depression. Only a complete physical will uncover other problems. The National Institute of Mental Health suggests that this exam should include:

A complete medical workup

- A complete history of current and past symptoms
- Questions about illnesses and other family members
- Questions about mood, memory, and changes in relationships and life situations

- Questions about alcohol and drug use and about suicidal thoughts.

Treatment for depression basically comes in two forms: psychotherapy, sometimes known as “talk therapy,” and prescription medications, known as antidepressants. For most forms of depression, a combination of therapy and medication is advised. The medication quickly begins to work on the person’s symptoms, and the psychotherapy helps the person learn more effective ways to deal with life’s problems. Most people begin to feel better within a few weeks.

People must also remember to stay personally active in their fight against depression. They can:

- Get out of the house regularly
- •Keep from withdrawing socially
- Return to a hobby they once enjoyed
- Keep in touch with others, if only for a few minutes a day
- Join a support group
- Participate in a peer counseling program.

Antidepressants

Various forms of these drugs attempt to bring the brain’s chemical imbalances back to normal. Tricyclics have been around since the 1950s. Because tricyclics help with nerve-related pain and with depression, they often are prescribed to people with SCI.

The newest drugs are serotonin reuptake inhibitors or SRIs. The development of SRIs helped researchers see the strong connection between chemical imbalances in the brain and depression. The most well-known and often used SRI is Prozac.

SRIs have fewer and weaker side effects and are the most often prescribed antidepressant. They also are becoming the prescribed drug of choice in the treatment of major depression for people with SCI.

Side effects from antidepressants usually are mild and not long-lasting. The general side effects common to all the antidepressants are:

- Sleepiness
- Weakened urine stream
- Changes in sexual function
- Dizziness
- Headache.

Among the tricyclics the side effects may include:

- Blurry vision
- Constipation
- Dry mouth.

Among the SRIs, the side effects may include:

- Momentary nausea
- Nervousness and insomnia
- Agitation.

Contact your doctor if these side effects persist or are troublesome. Antidepressants are not habit forming. They should also not be confused with sedatives or anti-anxiety drugs. These drugs sometimes are prescribed along with antidepressants, but they cannot be taken alone as treatment for a depressive state.

People respond differently to antidepressants, so many times doctors readjust dosages or change drugs to get the best results. However, as many as 30 to 40 percent of patients fail to respond satisfactorily to SRIs and a significant number fail to achieve long-term remission. Like any drug, antidepressants should be used carefully. People on antidepressants should:

- Take the drug for awhile before deciding it doesn't help
- Tell their doctor about other medications they are taking
- Not take other prescribed and over-the-counter drugs without talking to their doctor
- Avoid alcohol and drugs that are not monitored by a doctor.

Psychotherapy

Antidepressants work on the body's chemistry. But often people's problems with feelings of low self-esteem, hopelessness, sadness, failure to enjoy life, and irritability are tied to things that have happened to them or to the kinds of relationships they have with other people. These types of problems respond to psychotherapy. Many people are helped by talking over their problems with a mental health professional, such as a psychologist, psychiatrist, counselor, or social worker.

Two types of psychotherapy — cognitive/behavioral and interpersonal— work well for depression. In the interpersonal approach, the therapist looks at a person's relationships. He or she will help the depressed person find ways to strengthen his or her relationships and to work through feelings about SCI and the life changes it brought.

Cognitive/behavioral therapy is more short-term. Sometimes the person meets with a therapist for as few as 10 visits. The therapist helps to stop a person's negative thinking.

"No one likes me" and the behaviors that invite depression — being alone, sleeping too much, poor eating. These harmful thoughts and behaviors are replaced with thoughts that build self-esteem and activities that make life more enjoyable.

Studies have shown that people with certain behavior traits or personal habits are more likely to respond to treatment for depression. These people:

- Reflect on life
- Think about ideas
- Are organized
- Plan
- Set goals
- Carry out their duties
- Have a job
- Are not overly angry at themselves or others
- See more than one way to approach a problem and to solve it
- Can pinpoint the time when they started feeling depressed
- Have meaningful relationships with others.

The behavior traits of people who respond to treatment for depression give clues to the types of things people with SCI can do for themselves when they are fighting depression.

Helping yourself

Before their SCI, people with a tendency toward depression may have had ways to lift their spirits when they felt sad. They fought depression with personal strategies like taking a hike, playing golf, or digging in their garden. After the injury, however, their coping mechanisms

may no longer be available. They may find themselves not only feeling depressed, but also having to find new ways to fight depression.

Bill Diehm, a clinical psychologist and college teacher, had postpolio syndrome. He became disabled to the point that all he could predictably move was the thumb and index finger on one hand — enough movement to type at his computer and to operate an electric wheelchair.

In *The Second 50 Years: A Reference Manual for Senior Citizens*, a book he co-authored, he shares his tips for coping with depression. Some people may disagree with Diehm's simple and basic approach to fighting depression, but his approach enabled him to lead a productive life despite severe physical limitations.

1. Ask for help. When you can ask for help it means you have hope.
2. Take stock of your resources. Don't concentrate on your faults or failures. Count your skills, your friends and the good things in your life.
3. Keep yourself physically active.
4. Inactivity feeds depression. Get something, anything, done.
5. Take care of yourself.
6. Make sure you are well-groomed, you eat nutritious food, get enough rest and find something or someone to make you laugh.
7. Act as if you were the happiest person around.
8. "Some people think that the feeling comes first," writes Diehm. "I disagree; the decision comes first. Act happy, and the feeling will follow."
9. Talk positively, and drop negative words.
10. Your mind will respond to what it hears coming out of your mouth.
11. Picture positive things, practice peaceful meditation and positive thoughts.

Helpful resources

The Depression/Awareness, Recognition, and Treatment (D/ART) Program sponsored by the National Institute of Mental Health offers free information about depression. Call 1-800-421-4211 and leave your name and address. Or write D/ART at the following address: D/ART Public Inquiries National Institute of Mental Health Room 7C-02, 5600 Fishers Lane Rockville, MD 20857

You can also request information from the following agencies:

National Alliance for the Mentally Ill
200 N. Glebe Road, Suite 1015
Arlington, VA 22203-3 754
703-524-7600 1-800-950-NAMI

National Depressive and Manic Depressive Association
730 N. Franklin, Suite 501
Chicago, IL 60601
312-642-0049: 1-800-826-3632

National Foundation for Depressive Illness, Inc.
P.O. Box 2257
New York, NY 10016
212-268-4260: 1-800-248-4344

National Mental Health Association
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Glossary

Antidepressant (an'-te-de-pres-ent) Drugs widely used in the treatment of mental and nerve conditions.

Depression (de-presh'-un) A condition marked by a shift to sadness in a person's mood and in the way a person looks at the world and his or her self-worth. Depression shifts to being major depression when it interferes with a person's ability to function in daily life and changes how the person works, sleeps, eats, looks and behaves.

Dopamine (doe-pc-mean) A chemical essential to normal nerve activity.

Dysthymia (dis'-time-ee-uh) A less severe form of depression with long-term symptoms that do not disable someone, but that keep him or her from functioning well or from feeling good.

Insomnia (in-som-ne-nh) A chronic inability to sleep.

Lethargy (le-thar'-gee) Sluggish indifference, disinterest.

Neurotransmitter (noor'o-trans-mit-ter) Chemical that transmits messages to the brain.

Post-polio syndrome A degenerative illness that affects people who have had polio, a virus that attacks the central nervous system. The syndrome, which often affects movement in the arms and legs, can surface many years after the first bout of polio.

Psychiatrist (sigh-ki-'e-trist) A medical doctor who specializes in the study, diagnosis, treatment, and prevention of mental illness.

Psychologist (sigh-kol'-e-gist) A person with an advanced degree in counseling.

Psychotherapy (sigh'-ko-ther'-eh-pee) Using a person's mental abilities to treat their mental, emotional, or nervous disorders.

Schizophrenia (skit'-se-fre'-nee-a) A mental illness characterized by a withdrawal from reality and sometimes abnormal behavior.

Seasonal Affective Disorder (SAD) A pattern of depressive illness that occurs in the fall and leaves in the spring.

Serotonin (sir-o-toe-nin) A chemical compound found in the body, especially the brain.