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# WOMEN AND DEPRESSION

National Institute of Mental Health

## DISCOVERING HOPE

# Contents


What is depression? 2

What are the different forms of depression? 3

What are the basic symptoms of depression? 4

What causes depression in women? 5

What illnesses often coexist with depression in women? 8

How does depression affect adolescent girls? 9

How does depression affect older women? 10

How is depression diagnosed and treated? 11

What efforts are underway to improve treatment? 21

How can I help a friend or relative who is depressed? 22

How can I help myself if I am depressed? 23

Where can I go for help? 24

What if I or someone I know is in crisis? 25

Citations 26

For more information 28

## What is depression?

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a woman has a depressive disorder, it interferes with daily life and normal functioning, and causes pain for both the woman with the disorder and those who care about her. Depression is a common but serious illness, and most who have it need treatment to get better.

Depression affects both men and women, but more women than men are likely to be diagnosed with depression in any given year.[1] Efforts to explain this difference are ongoing, as researchers explore certain factors (biological, social, etc.) that are unique to women.

Many women with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment.

*Depression affects both men and women...*

*...but more women than men are likely to be diagnosed with depression in any given year.*

## What are the different forms of depression?

There are several forms of depressive disorders that occur in both women and men. The most common are major depressive disorder and dysthymic disorder. Minor depression is also common.

**Major depressive disorder**, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

**Dysthymic disorder**, also called dysthymia, is characterized by depressive symptoms that are long-term (e.g., two years or longer) but less severe than those of major depression. Dysthymia may not disable a person, but it prevents one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Minor depression may also occur. Symptoms of minor depression are similar to major depression and dysthymia, but they are less severe and/or are usually shorter term.

Some forms of depressive disorder have slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include the following:

- **Psychotic depression** occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality; seeing, hearing, smelling or feeling things that others can't detect (hallucinations); and having strong beliefs that are false, such as believing you are the president (delusions).
- **Seasonal affective disorder** (SAD) is characterized by a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy also can reduce SAD symptoms, either alone or in combination with light therapy.[2]

**Bipolar disorder,** also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression). More information about bipolar disorder is available at http://www.nimh.nih.gov/healthinformation/bipolarmenu.cfm.

## What are the basic symptoms of depression?

Women with depressive illnesses do not all experience the same symptoms. In addition, the severity and frequency of symptoms, and how long they last, will vary depending on the individual and her particular illness. Symptoms of depression include:

- *Persistent sad, anxious or "empty" feelings*
- *Feelings of hopelessness and/or pessimism*
- *Irritability, restlessness, anxiety*
- *Feelings of guilt, worthlessness and/or helplessness*
- *Loss of interest in activities or hobbies once pleasurable, including sex*
- *Fatigue and decreased energy*
- *Difficulty concentrating, remembering details and making decisions*
- *Insomnia, waking up during the night, or excessive sleeping*
- *Overeating, or appetite loss*
- *Thoughts of suicide, suicide attempts*
- *Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment*

## What causes depression in women?

Scientists are examining many potential causes for and contributing factors to women's increased risk for depression. It is likely that genetic, biological, chemical, hormonal, environmental, psychological, and social factors all intersect to contribute to depression.

### Genetics

If a woman has a family history of depression, she may be more at risk of developing the illness. However, this is not a hard and fast rule. Depression can occur in women without family histories of depression, and women from families with a history of depression may not develop depression themselves. Genetics research indicates that the risk for developing depression likely involves the combination of multiple genes with environmental or other factors.[3]

### Chemicals and hormones

Brain chemistry appears to be a significant factor in depressive disorders. Modern brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people suffering from depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleep, appetite and behavior don't appear to be functioning normally. In addition, important neurotransmitters—chemicals that brain cells use to communicate—appear to be out of balance. But these images do not reveal WHY the depression has occurred.

Scientists are also studying the influence of female hormones, which change throughout life. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. Specific times during a woman's life are of particular interest, including puberty; the times before menstrual periods; before, during, and just after pregnancy (postpartum); and just prior to and during menopause (perimenopause).

## Premenstrual dysphoric disorder

Some women may be susceptible to a severe form of premenstrual syndrome called premenstrual dysphoric disorder (PMDD). Women affected by PMDD typically experience depression, anxiety, irritability and mood swings the week before menstruation, in such a way that interferes with their normal functioning. Women with debilitating PMDD do not necessarily have unusual hormone changes, but they do have different responses to these changes.[4] They may also have a history of other mood disorders and differences in brain chemistry that cause them to be more sensitive to menstruation-related hormone changes. Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness.[5,6,7]

## Postpartum depression

Women are particularly vulnerable to depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. Many new mothers experience a brief episode of mild mood changes known as the "baby blues," but some will suffer from postpartum depression, a much more serious condition that requires active treatment and emotional support for the new mother. One study found that postpartum women are at an increased risk for several mental disorders, including depression, for several months after childbirth.[8]

Some studies suggest that women who experience postpartum depression often have had prior depressive episodes. Some experience it during their pregnancies, but it often goes undetected. Research suggests that visits to the doctor may be good opportunities for screening for depression both during pregnancy and in the postpartum period.[9,10]

## Menopause

Hormonal changes increase during the transition between premenopause to menopause. While some women may transition into menopause without any problems with mood, others experience an increased risk for depression. This seems to occur even among women without a history of depression.[11,12] However, depression becomes less common for women during the post-menopause period.[13]

## Stress

Stressful life events such as trauma, loss of a loved one, a difficult relationship or any stressful situation—whether welcome or unwelcome—often occur before a depressive episode. Additional work and home responsibilities, caring for children and aging parents, abuse, and poverty also may trigger a depressive episode. Evidence suggests that women respond differently than men to these events, making them more prone to depression. In fact, research indicates that women respond in such a way that prolongs their feelings of stress more so than men, increasing the risk for depression.[14] However, it is unclear why some women faced with enormous challenges develop depression, and some with similar challenges do not.

## What illnesses often coexist with depression in women?

Depression often coexists with other illnesses that may precede the depression, follow it, cause it, be a consequence of it, or a combination of these. It is likely that the interplay between depression and other illnesses differs for every person and situation. Regardless, these other coexisting illnesses need to be diagnosed and treated.

Depression often coexists with eating disorders such as anorexia nervosa, bulimia nervosa and others, especially among women. Anxiety disorders, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia and generalized anxiety disorder, also sometimes accompany depression.[15,16] Women are more prone than men to having a coexisting anxiety disorder.[17] Women suffering from PTSD, which can result after a person endures a terrifying ordeal or event, are especially prone to having depression.

Although more common among men than women, alcohol and substance abuse or dependence may occur at the same time as depression.[17,15] Research has indicated that among both sexes, the coexistence of mood disorders and substance abuse is common among the U.S. population.[18]

Depression also often coexists with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes, Parkinson's disease, thyroid problems and multiple sclerosis, and may even make symptoms of the illness worse.[19] Studies have shown that both women and men who have depression in addition to a serious medical illness tend to have more severe symptoms of both illnesses. They also have more difficulty adapting to their medical condition, and more medical costs than those who do not have coexisting depression. Research has shown that treating the depression along with the coexisting illness will help ease both conditions.[20]

## How does depression affect adolescent girls?

Before adolescence, girls and boys experience depression at about the same frequency.[13] By adolescence, however, girls become more likely to experience depression than boys.

Research points to several possible reasons for this imbalance. The biological and hormonal changes that occur during puberty likely contribute to the sharp increase in rates of depression among adolescent girls. In addition, research has suggested that girls are more likely than boys to continue feeling bad after experiencing difficult situations or events, suggesting they are more prone to depression.[21] Another study found that girls tended to doubt themselves, doubt their problem-solving abilities and view their problems as unsolvable more so than boys. The girls with these views were more likely to have depressive symptoms as well. Girls also tended to need a higher degree of approval and success to feel secure than boys.[22]

Finally, girls may undergo more hardships, such as poverty, poor education, childhood sexual abuse, and other traumas than boys. One study found that more than 70 percent of depressed girls experienced a difficult or stressful life event prior to a depressive episode, as compared with only 14 percent of boys.[23]

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## How does depression affect older women?

As with other age groups, more older women than older men experience depression, but rates decrease among women after menopause.[13] Evidence suggests that depression in post-menopausal women generally occurs in women with prior histories of depression. In any case, depression is NOT a normal part of aging.

The death of a spouse or loved one, moving from work into retirement, or dealing with a chronic illness can leave women and men alike feeling sad or distressed. After a period of adjustment, many older women can regain their emotional balance, but others do not and may develop depression. When older women do suffer from depression, it may be overlooked because older adults may be less willing to discuss feelings of sadness or grief, or they may have less obvious symptoms of depression. As a result, their doctors may be less likely to suspect or spot it.

For older adults who experience depression for the first time later in life, other factors, such as changes in the brain or body, may be at play. For example, older adults may suffer from restricted blood flow, a condition called ischemia. Over time, blood vessels become less flexible. They may harden and prevent blood from flowing normally to the body's organs, including the brain. If this occurs, an older adult with no family or personal history of depression may develop what some doctors call "vascular depression." Those with vascular depression also may be at risk for a coexisting cardiovascular illness, such as heart disease or a stroke.[24]

## How is depression diagnosed and treated?

Depressive illnesses, even the most severe cases, are highly treatable disorders. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that a recurrence of the depression can be prevented.

The first step to getting appropriate treatment is to visit a doctor. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. In addition, it is important to rule out depression that is associated with another mental illness called bipolar disorder. (For more information about bipolar disorder, visit the National Institute of Mental Health's (NIMH) Web site at http://www.nimh.nih.gov). A doctor can rule out these possibilities by conducting a physical examination, interview, and/or lab tests, depending on the medical condition. If a medical condition and bipolar disorder can be ruled out, the physician should conduct a psychological evaluation or refer the person to a mental health professional.

*...the earlier that treatment can begin, the more effective it is.*

The doctor or mental health professional will conduct a complete diagnostic evaluation. He or she should get a complete history of symptoms, including when they started, how long they have lasted, their severity, whether they have occurred before, and if so, how they were treated. He or she should also ask if there is a family history of depression. In addition, he or she should ask if the person is using alcohol or drugs, and whether the person is thinking about death or suicide.

Once diagnosed, a person with depression can be treated with a number of methods. The most common treatment methods are medication and psychotherapy.

## Medication

Antidepressants work to normalize naturally occurring brain chemicals called neurotransmitters, notably serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists studying depression have found that these particular chemicals are involved in regulating mood, but they are unsure of the exact ways in which they work.

The newest and most popular types of antidepressant medications are called selective serotonin reuptake inhibitors (SSRIs) and include:

- fluoxetine (Prozac)
- citalopram(Celexa)
- sertraline (Zoloft)
- paroxetine (Paxil)
- escitalopram (Lexapro)
- fluvoxamine (Luvox)

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include:

- venlafaxine (Effexor)
- duloxetine (Cymbalta)

SSRIs and SNRIs tend to have fewer side effects and are more popular than the older classes of antidepressants, such as tricyclics – named for their chemical structure – and monoamine oxidase inhibitors (MAOIs). However, medications affect everyone differently. There is no one-size-fits-all approach to medication. Therefore, for some people, tricyclics or MAOIs may be the best choice.

People taking MAOIs must adhere to significant food and medicinal restrictions to avoid potentially serious interactions. They must avoid certain foods that contain high levels of the chemical tyramine, which is found in many cheeses, wines and pickles, and some medications including decongestants. Most MAOIs interact with tyramine in such a way that may cause a sharp increase in blood pres-

sure, which may lead to a stroke. A doctor should give a person taking an MAOI a complete list of prohibited foods, medicines and substances.

For all classes of antidepressants, people must take regular doses for at least three to four weeks, sometimes longer, before they are likely to experience a full effect. They should continue taking the medication for an amount of time specified by their doctor, even if they are feeling better, to prevent a relapse of the depression. The decision to stop taking medication should be made by the person and her doctor together, and should be done only under the doctor's supervision. Some medications need to be gradually stopped to give the body time to adjust. Although they are not habit-forming or addictive, abruptly ending an antidepressant can cause withdrawal symptoms or lead to a relapse. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely.

In addition, if one medication does not work, people should be open to trying another. Research funded by NIMH has shown that those who did not get well after taking a first medication often fared better after they switched to a different medication or added another medication to their existing one.[25,26]

Sometimes other medications, such as stimulants or antianxiety medications, are used in conjunction with an antidepressant, especially if the person has a coexisting illness. However, neither antianxiety medications nor stimulants are effective against depression when taken alone, and both should be taken only under a doctor's close supervision.

*...people who did not get well after taking a first medication often fared better after they switched to a different medication, or added another medication to their existing one.*

## Is it safe to take antidepressant medication during pregnancy?

At one time, doctors assumed that pregnancy was accompanied by a natural feeling of well being, and that depression during pregnancy was rare, or never occurred at all. However, recent studies have shown that women can have depression while pregnant, especially if they have a prior history of the illness. In fact, a majority of women with a history of depression will likely relapse during pregnancy if they stop taking their antidepressant medication either prior to conception or early in the pregnancy, putting both mother and baby at risk.[27,12]

However, antidepressant medications do pass across the placental barrier, potentially exposing the developing fetus to the medication. Some research suggests the use of SSRIs during pregnancy is associated with miscarriage and/or birth defects, but other studies do not support this.[28] Some studies have indicated that fetuses exposed to SSRIs during the third trimester may be born with "withdrawal" symptoms such as breathing problems, jitteriness, irritability, difficulty feeding, or hypoglycemia. In 2004, the U.S. Food and Drug Administration (FDA) issued a warning against the use of SSRIs in the late third trimester, suggesting that clinicians gradually taper expectant mothers off SSRIs in the third trimester to avoid any ill effects on the baby.[29]

Although some studies suggest that exposure to SSRIs in pregnancy may have adverse effects on the infant, generally they are mild and short-lived, and no deaths have been reported. On the flip side, women who stop taking their antidepressant medication during pregnancy increase their risk for developing depression again and may put both themselves and their infant at risk.[28,12]

In light of these mixed results, women and their doctors need to consider the potential risks and benefits to both mother and fetus of taking an antidepressant during pregnancy, and make decisions based on individual needs and circumstances. In some cases, a woman and her doctor may decide to taper her antidepressant dose during the last month of pregnancy to minimize the newborn's withdrawal symptoms, and after delivery, return to a full dose during the vulnerable postpartum period.

### Is it safe to take antidepressant medication while breastfeeding?

Antidepressants are excreted in breast milk, usually in very small amounts. The amount an infant receives is usually so small that it does not register in blood tests. Few problems are seen among infants nursing from mothers who are taking antidepressants. However, as with antidepressant use during pregnancy, both the risks and benefits to the mother and infant should be taken into account when deciding whether to take an antidepressant while breastfeeding.[30]

*Women and their doctors need to consider the potential risks and benefits to both mother and fetus of taking an antidepressant during pregnancy...*

## What are the side effects of antidepressants?

Antidepressants may cause mild and often temporary side effects in some people, but usually they are not long-term. **However, any unusual reactions or side effects that interfere with normal functioning or are persistent or troublesome should be reported to a doctor immediately.**

The most common side effects associated with SSRIs and SNRIs include:

- Headache—usually temporary and will subside.
- Nausea—temporary and usually short-lived.
- Insomnia and nervousness (trouble falling asleep or waking often during the night)—may occur during the first few weeks but often subside over time or if the dose is reduced.
- Agitation (e.g., feeling jittery).
- Sexual problems—women can experience sexual problems including reduced sex drive, or inability to have an orgasm.

Tricyclic antidepressants also can cause side effects including:

- Dry mouth—it is helpful to drink plenty of water, chew gum, and clean teeth daily.
- Constipation—it is helpful to eat more bran cereals, prunes, fruits, and vegetables.
- Bladder problems—emptying the bladder may be difficult, and the urine stream may not be as strong as usual.
- Sexual problems—sexual functioning may change, and side effects are similar to those from SSRIs and SNRIs.
- Blurred vision—often passes soon and usually will not require a new corrective lenses prescription.
- Drowsiness during the day—usually passes soon, but driving or operating heavy machinery should be avoided while drowsiness occurs. These more sedating antidepressants are generally taken at bedtime to help sleep and minimize daytime drowsiness.

## FDA warning on antidepressants

Despite the fact that SSRIs and other antidepressants are generally safe and reliable, some studies have shown that they may have unintentional effects on some people, especially young people. In 2004, the FDA reviewed data from studies of antidepressants that involved nearly 4,400 children and teenagers being treated for depression. The review showed that 4% of those who took antidepressants thought about or attempted suicide (although no suicides occurred), compared to 2% of those who took sugar pills (placebo).

This information prompted the FDA, in 2005, to adopt a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and teenagers taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the black box warning on their labels to include young patients up through age 24 who are taking these medications for depression treatment. A "black box" warning is the most serious type of warning on prescription drug labeling.

The warning also emphasizes that children, teenagers and young adults taking antidepressants should be closely monitored, especially during the first four weeks of treatment, for any worsening depression, suicidal thinking or behavior. These include any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations.

Results of a review of pediatric trials between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders. The study was funded in part by NIMH.[31]

## What about St. John's wort?

The extract from the herb St. John's wort (Hypericum perforatum), a bushy, wild-growing plant with yellow flowers, has been used for centuries in many folk and herbal remedies. Today in Europe, it is used extensively to treat mild to moderate depression. In the United States, it is a top-selling botanical product.

To address increasing American interest in St. John's wort, the National Institutes of Health (NIH) conducted a clinical trial to determine the effectiveness of the herb in treating adults suffering from major depression. Involving 340 patients diagnosed with major depression, the eight-week trial randomly assigned one-third of them to a uniform dose of St. John's wort, one-third to a commonly prescribed SSRI, and one-third to a placebo. The trial found that St. John's wort was no more effective than the placebo in treating major depression.[32] Another study is underway to look at the effectiveness of St. John's wort for treating mild or minor depression.

Other research has shown that St. John's wort can interact unfavorably with other drugs, including drugs used to control HIV infection. On February 10, 2000, the FDA issued a Public Health Advisory letter stating that the herb appears to interfere with certain drugs used to treat heart disease, depression, seizures, certain cancers, and organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Because of these and other potential interactions, people should always consult their doctors before taking any herbal supplement.

## Psychotherapy

Several types of psychotherapy—or "talk therapy"—can help people with depression.

Some regimens are short-term (10 to 20 weeks) and other regimens are longer-term, depending on the needs of the individual. Two main types of psychotherapies—cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT)—have been shown to be effective in treating depression. By teaching new ways of thinking and behaving, CBT helps people change negative styles of thinking and behaving that may contribute to their depression. IPT helps people understand and work through troubled personal relationships that may cause their depression or make it worse.

For mild to moderate depression, psychotherapy may be the best treatment option. However, for major depression or for certain people, psychotherapy may not be enough. Studies have indicated that for adolescents, a combination of medication and psychotherapy may be the most effective approach to treating major depression and reducing the likelihood for recurrence.[33] Similarly, a study examining depression treatment among older adults found that patients who responded to initial treatment of medication and IPT were less likely to have recurring depression if they continued their combination treatment for at least two years.[34]

*Several types of psychotherapy—or "talk therapy"— can help people with depression.*

## Electroconvulsive Therapy

For cases in which medication and/or psychotherapy does not help alleviate a person's treatment-resistant depression, electroconvulsive therapy (ECT) may be useful. ECT, formerly known as "shock therapy," used to have a negative reputation. But in recent years, it has greatly improved and can provide relief for people with severe depression who have not been able to feel better with other treatments.

Before ECT is administered, a patient takes a muscle relaxant and is put under brief anesthesia. She does not consciously feel the electrical impulse that is administered. A person typically will undergo ECT several times a week, and often will need to take an antidepressant or mood stabilizing medication to supplement the ECT treatments and prevent relapse. Although some people will need only a few courses of ECT, others may need maintenance ECT, usually once a week at first, then gradually decreasing to monthly treatments for up to one year.

ECT may cause some short-term side effects, including confusion, disorientation and memory loss. But these side effects typically clear shortly after treatment. Research has indicated that after one year of ECT treatments, patients showed no adverse cognitive effects.[35] A person should weigh the potential risks and benefits of ECT and discuss them with her doctor before deciding to undergo ECT treatment.

## What efforts are underway to improve treatment?

Researchers are looking for ways to better understand, diagnose and treat depression among all groups of people. New possible treatments, such as faster-acting antidepressants, are being tested that give hope to those who live with difficult-to-treat depression. Researchers are studying the risk factors for depression and how it affects the brain. NIMH continues to fund cutting-edge research into this debilitating disorder. For more information on NIMH-funded research on depression visit http://www.nimh.nih.gov.

## How can I help a friend or relative who is depressed?

If you know someone who has depression, the first and most important thing you can do is to help her get an appropriate diagnosis and treatment. You may need to make an appointment on her behalf and go with her to see the doctor. Encourage her to stay in treatment, or to seek different treatment if no improvement occurs after six to eight weeks.

In addition, you can also:

- Offer emotional support, understanding, patience and encouragement.
- Engage her in conversation, and listen carefully.
- Never disparage feelings she expresses, but point out realities and offer hope.
- Never ignore comments about suicide, and report them to your friend's or relative's therapist or doctor.
- Invite your friend or relative out for walks, outings and other activities. Keep trying if she declines, but don't push her to take on too much too soon. Although diversions and company are needed, too many demands may increase feelings of failure.
- Remind her that with time and treatment, the depression will lift.

## How can I help myself if I am depressed?

You may feel exhausted, helpless and hopeless. It may be extremely difficult to take any action to help yourself. But it is important to realize that these feelings are part of the depression and do not reflect actual circumstances. As you recognize your depression and begin treatment, negative thinking will fade. In the meantime:

- Engage in mild activity or exercise. Go to a movie, a ballgame, or another event or activity that you once enjoyed. Participate in religious, social or other activities.
- Set realistic goals for yourself.
- Break up large tasks into small ones, set some priorities and do what you can as you can.
- Try to spend time with other people and confide in a trusted friend or relative. Try not to isolate yourself, and let others help you.
- Expect your mood to improve gradually, not immediately. Do not expect to suddenly "snap out of" your depression. Often during treatment for depression, sleep and appetite will begin to improve before your depressed mood lifts.
- Postpone important decisions, such as getting married or divorced or changing jobs, until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation.
- Be confident that positive thinking will replace negative thoughts as your depression responds to treatment.

## Where can I go for help?

If you are unsure where to go for help, ask your family doctor. Others who can help are:

- Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors.
- Health maintenance organizations (HMOs).
- Community mental health centers.
- Hospital psychiatry departments and outpatient clinics.
- Mental health programs at universities or medical schools.
- State hospital outpatient clinics.
- Family services, social agencies or clergy.
- Peer support groups.
- Private clinics and facilities.
- Employee assistance programs.
- Local medical and/or psychiatric societies.

You can also check the phone book under "mental health," "health," "social services," "hotlines," or "physicians" for phone numbers and addresses. An emergency room doctor also can provide temporary help and can tell you where and how to get further help.

## What if I or someone I know is in crisis?

Women are more likely than men to attempt suicide. If you are thinking about harming yourself or attempting suicide, tell someone who can help immediately.

- Call your doctor.
- Call 911 for emergency services.
- Go to the nearest hospital emergency room.
- Call the toll-free, 24-hour hotline of the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255); TTY: 1-800-799-4TTY (4889) to be connected to a trained counselor at a suicide crisis center nearest you.

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