

Anti-Tips for Anti-Managers

Ever wonder how well meaning people become miserable managers? Here are a few tips for bringing out the worst in your employees:

- Never say thank you, your employees should do their jobs anyway
- Point out mistakes often, but avoid complements in case they "go to their heads"
- Document every mistake in case you need to fire them later
- Conduct all your coaching during the annual performance review, that way you can take care of everything at once
- Don't waste time listening to your employees, all they do is complain anyway
- Don't waste time talking to your employees, they can't do anything for your career
- Keep an eye on everybody all the time, in case they try to "goof off" or steal something
- Never promote your best workers, you can't afford to lose them
- Never offer training opportunities to your best workers, they don't need any
- Never let your direct reports talk to your boss, they might try to make you look bad

Upcoming Events

8th National Conference
Irish Association of Suicidology
Innovations in Preventing Youth Suicide
20th November, 2008
Sheraton Hotel, Athlone
www.ias.ie

3rd Asia Pacific Regional Conference of the International Association for Suicide Prevention
Suicide research and prevention in times of rapid change in the Asia Pacific Region: opportunities & challenges
October 31 - November 3, 2008
Hong Kong Convention Centre
Hong Kong
www.iasp1960.org

2009 - XXV IASP World Congress
27-31 October 2009
Montevideo, Uruguay
Contact person: Dr. Silvia Peláez
info@iasp2009.org

AAS 42nd Annual Conference
April 15-18, 2009
Westin St. Francis Hotel
San Francisco, CA
www.suicidology.org

If you would like to submit an article or if you wish to comment on any article published in this newsletter please contact the Editor: Josephine Scott. E-mail joscott@eircom.net



16 New Antrim St., Castlebar, Co. Mayo

Phone: +353 94 92 50858
Fax: +353 94 92 50859
Email: info@ias.ie
Web: www.ias.ie

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Who cares about suicide – a living mortality?

Between 70 to 90 per cent of patients who attempt or commit suicide have a psychiatric problem

Suicide is a wilful self-inflicted life-threatening act, which can result in death, and it is a Latin word *suicidium*, from *sui caedere*, to kill oneself. Parasuicide is a behavioural analogue of suicide but without considering a psychological orientation towards death being in any way essential to the condition suicide. The majority of those who commit suicide have some form of mental disorder and between 70 to 90 per cent of patients who attempt or commit suicide have a psychiatric problem. Out of these, 15 per cent are depressive, 15 percent are alcoholics, and nine to 13 per cent are schizophrenics.

There is 100 times risk of suicide within a year of parasuicides among patients and the risk of suicide is high after discharge from a psychiatric facility. Research has shown that two thirds of suicide victims had contacted GP in the previous month and 40 per cent had done so in the previous week. A quarter were seeing a psychiatrist and half of these had seen the psychiatrist in the previous week. Suicide was most likely to occur within the first week of hospitalisation and within the first week of discharge.

History of suicide

- Religious sanctions were lifted in 1823;
- Legal sanction was lifted in 1870;
- Suicide ward/special night watch were established in 1875;
- Close observation/restraints/ routine search were introduced in 1885;
- Decriminalisation happened in 1968

Incidence

Suicide is the second commonest cause of death in the UK and for every suicide, 30 non-fatal attempts of self-harm occur. One person dies every two hours in England, which is 5,000 deaths per year and suicide is the commonest cause of death in men under the age of 35 years. Men are three times more likely to commit suicide as compared to women. Men between the ages of 15 to 20 have high incidence of suicide. The commonest method of suicide by men and women is self-poisoning using car exhaust fumes and overdose respectively (see table 1).

In the UK, suicide is the third cause of death in children as two per cent of children end their lives by suicide. New Zealand figures show (Table 2) that 13.1 per 100,000 people committed suicide in 2002 – 2004, a rate that is higher than England and Wales. One million suicides and 10 million parasuicides happen each year worldwide (Govt. statistics 2002).

Irish statistics are showing a slow decline in suicide deaths each year but Dublin shows the lowest rate as compared to rural areas (Table 3).

Management of suicide

Suicide prevention is a multi-sectoral approach which should involve individuals, families, community organisations, researchers, educational institutions, local health services (GP psychiatric, and drug addiction) volunteers, social services, local and non-government organisations. Low education, low social status, gambling problems, unemployment, stigma,

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A Railroad Track Linking Metal Illness and Wellness

Within the spectrum of mental health, the emphasis has primarily been on mental illness. Mental wellness has received relatively little attention. A comprehensive approach to mental health requires an in-depth understanding of both ends of the spectrum and the stages in between. All human beings share similar dietary requirements and needs. Irrespective of the person's dietary habits, culture or country of origin, protein, carbohydrates, fats, minerals and vitamins are required for healthy functioning. Similarly, while mental wellness is influenced by a wide range of personal, emotional, psychological, social, relational, circumstantial and cultural factors, certain elements have a universal importance to mental health.

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Poor Dental Hygiene Linked To Heart Attacks

Poor dental hygiene can lead to heart disease according to new research. Lead researcher Dr Steve Kerrigan and his team from the School of Pharmacy and the Department of Molecular Cellular Therapeutics at the RCSI are investigating how oral bacteria stick to human blood platelets and cause them to clot or clump together within blood vessels. Dr Kerrigan said: "The mouth is probably the dirtiest place in the human body, with over 500 different species of bacteria. We have recently identified two receptors (proteins) on oral bacteria that we believe play a major role in recognising and sticking to platelets. The results of the study suggest that we have identified some of the mechanisms oral bacteria use to inappropriately clot or clump platelets in the blood vessels." He said that by understanding the exact mechanism through which bacteria stick to platelets and cause them to clump together we can gain better insights for the development of novel therapies to treat this disease. "However, all this can be avoided with proper dental hygiene by brushing and flossing regularly," he added.

Irish Medical News

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A Railroad Track Linking Mental Illness and Wellness *continued from page 1*

Two vital elements are what I refer to as "selfhood", and dealing effectively with the world, within communities supporting mental wellness. I think of selfhood as encompassing all aspects of being a person - a self - just as other terms such as childhood, womanhood and manhood encapsulate the characteristics and experience of that particular state. For me, selfhood refers to all that applies to being a person, the inner, private world of the individual as they go through their life journey. Effective dealing with the world involves how we handle issues such as communication, relating, change, loss, failure, conflict, choice and decision-making, the unexpected, hopes and dreams not working out, and how well our needs are met throughout our experience of living.

The importance of selfhood and effective dealing with the world is echoed both nationally and internationally. According to the 2006 Irish mental health policy document A Vision for Change, components of mental health include an inner-felt sense of subjective wellbeing, personal autonomy, the ability to reach one's potential, the ability to cope with and manage our lives, resilience, coping with change and stress, participating fully and satisfactorily in life. According to the World Health Organisation, key aspects of a person's quality of life are their perceptions of themselves and of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns and their experience of their interactions with the world in which they live.

Preceding the onset of major mental health problems there is often a gradual, extensive loss of selfhood. The person's methods of dealing with their world become increasingly frantic and compromised as they become increasingly overwhelmed. People diagnosed as having schizophrenia have generally experienced extensive loss of selfhood, often unnoticed and unresolved. It manifests as a major loss of identity and self-confidence, severe withdrawal and major perceived inner powerlessness. Hallucinations, delusions, severe anxiety and other experiences associated with schizophrenia can be understood within the context of catastrophic loss of selfhood, subsequent dealing with one's world and, consequently, vast unmet need within one's life. People diagnosed with anorexia, manic depression and depression tend to have a low sense of selfhood which contributes to the frequently experienced anxiety. A person's sense of selfhood can improve if it is recognised and worked with appropriately. Mental health can be understood as a continuum between mental wellness and mental illness. An approach to mental health which does not sufficiently prioritise mental wellness. It lacks cohesive pathways and connections with mental wellness, akin to a railroad track between two destinations which either ends suddenly in the middle of nowhere or has several stretches of track missing. The mental wellness-illness spectrum approach overcomes this vacuum, enabling us to see mental health as a continuum between wellness and illness, facilitating the creation of pathways back to mental wellness.

Utilising this spectrum provides bridges and pathways, signposts for people to edge their way back towards recovery of selfhood and effective dealing with the world at a pace that works for them not merely the easing of symptoms, though this too is important. The individual's life, experiences, needs, struggles worldview, their senses of selfhood and how they deal with the world need to be routinely included within mental health assessments and interventions. A central aim of mental health interventions is to restore mental wellness to the highest possible degree. A comprehensive understanding, clarification and description of mental wellness and the mental wellness-illness spectrum is a prerequisite to the development of effective interventions for mental health problems: clear road maps to mental health promotion and the prevention of mental health problems.

An understanding of the full spectrum, ranging from mental wellness to mental illness, enhances understanding of where on this spectrum and individual might be, clarifying appropriate next steps, reducing the risk of employing interventions which either impede recovery or are too many steps ahead for that particular person at that time. A well-developed sense of selfhood greatly enhances our ability to deal with the realities of today's challenging world such as change, relating, growth, loss, the unexpected, healthy boundaries and carving out a fulfilling and meaningful life.

*Terry Lunch, Psychotherapist,
Irish Times, Health Supplement*

Who cares about suicide – a living mortality?

continued from page 1

child abuse and interpersonal violence should also be taken into account, whenever a plan is designed to reduce the suicide rate (Table 4).

Table 1: Methods of suicide

Men	Women
Poisoning...50 per cent	Hanging...50 per cent
Hanging	Poisoning
Jumping	Gas
Gas	Jumping
Other	Other

Table 2: Suicide Statistics in NZ

- Suicide was the ninth most common cause of mortality in NZ: two per cent in 2003
- Suicide and DSH injuries – 28.8 per cent in 2003
- 13.1 per 100,000 in 2002-2004
- Three per cent lower than 2001-2003
- Males to females ratio 3.1:1
- Females (15-19) and males (over 85) are the highest risk groups

Table 3: Irish statistics 2004

- Total deaths from suicide were 457 in 2004 (11.30 per 100,000).
- This compares to a rate of 11.6 per 100,000 population in 2003 and 12.20 in 2002
- Offaly has the highest suicide rate in Ireland with a rate of 18.26 per 100,000 population
- The second, third and fourth highest rates by counties were Tipperary North, Sligo and Meath with rates of 17.61, 16.85, and 16.68 per 100,000
- Roscommon recorded the lowest rate of 1.83 per 100,000
- Dublin's and Cork's suicide rates were 9.04, and 15 per 100,000 populations

Table 4

Prevention	Intervention	Postvention
Public education;	Assessment of risk factors	Bereavement:
Control of access to suicide means;	Psychiatric problems: alcohol depression;	Staff counselling/support;
Research/audit of services;	Physical problems: cancer; Audit	MDT meeting
Control of alcohol consumption;	Psychosocial problems: job loss, housing	
Improve healthcare quality;	Financial problems: loans	
Equal access to education;		
Models of suicide prevention.		

Omega-3 Fatty Acids Lessen Risk On Age-Related Macular Degeneration

Eating fish and other foods high in omega-3 fatty acids is associated with reduced risk of the eye disease age related macular degeneration (AMD), according to a new meta-analysis. The researchers conducted a systematic review of studies published before May 2007 evaluating fish consumption and the overall omega-3 fatty acid intake in the prevention of AMD.

A total of nine studies were identified with 88,974 participants, including 3,203 individuals with AMD. When results from all nine studies were combined, a high dietary intake of omega-3 fatty acids was associated with a 38 per cent reduction in the risk of late AMD, while eating fish twice a week was associated with a reduced risk of both early and late AMD. "Long-chain omega-3 fatty acids, docosahexaenoic acid in particular, form an integral part of the neural retina," the layer of nerve cells in the retina, the authors write. Outer cells of the retina are continually shed and regenerated, and deficiencies of omega-3 fatty acids may therefore initiate AMD. "A diet rich in omega-3 fatty acids and fish, as a proxy for long-chain omega-3 fatty acid intake, has therefore been hypothesised as a means to prevent AMD." Despite such findings, the researchers cautioned "there is insufficient evidence from the current literature, with few prospective studies and no randomised clinical trials, to support their routine consumption for AMD prevention"

Irish Medical Times

*Dr. Muhammad Arshad
Prof. Michael Fitzgerald
Irish Medical News*

Prozac may help to curb disease activity in MS patients

The antidepressant Prozac may help to curb disease activity in the relapsing remitting form of multiple sclerosis (MS), according to a new study. The study's research team randomly allocated 40 patients with the relapsing remitting form of MS to treatment with either 20mg daily of fluoxetine (Prozac) or placebo for a period of 24 weeks. Detailed brain scans with magnetic resonance imaging every four weeks were used to check for new areas of neurological inflammation, a hallmark of active disease.

In total, 38 patients completed the study. The scans showed that those in the placebo group had more new areas of inflammation than those treated with Prozac. The effects began to become evident after eight weeks, which corresponds to the time the selective serotonin reuptake inhibitor class of drugs, of which Prozac is one, start to work on relieving depression. The average number of new areas affected was more than five in the group given the placebo compared with just under two in the group given Prozac.

One in four scans from patients treated with Prozac showed new areas of inflammation compared with four out of 10 of those taking placebo. During the last 16 weeks of treatment, almost two thirds of patients in the group given Prozac had no new areas of inflammation compared with only one in four in the group given placebo.

The authors caution that their study was small, and larger studies would be needed before firm conclusions could be drawn. But they conclude that their results are 'sufficiently encouraging to justify further studies with fluoxetine in patients with MS', adding that higher doses and treatment combinations with other drugs that alter the immune response, should be considered.

Irish Medical Times

VITAMIN C that is injected rather than swallowed can destroy cancer, research has shown

The therapy halved the growth of aggressive tumours in mice, killing cancer cells while leaving healthy tissue unharmed. It could provide a new lifeline for patients with a poor prognosis and few treatment options, scientists suggest. Tackling cancer with vitamin C would also have the added advantage of being cheap. Usually the body keeps a tight rein on vitamin C levels in the blood. But scientists found that the mechanism can be by-passed if the vitamin is injected straight into the bloodstream instead of passing through the digestive system. When this is done it releases the powerful anti-cancer potential of the vitamin, according to the researchers.

Experiments showed that high levels of vitamin C in the blood generate hydrogen peroxide, which is lethal to tumours. The chemical forms in the spaces between cancer cells, damaging membranes, upsetting metabolism, and scrambling DNA. Even the growth of aggressive, hard-to-treat cancers was held back in the studies. But healthy tissues appeared to resist the effects. The use of high dose vitamin C as a complementary or alternative cancer treatment has a long history dating back to the 1970s. Patients have taken the vitamin both by mouth and intravenously. But despite some positive outcomes, reliable evidence that the therapy works has been lacking.

Experts for this reason claims that vitamin C can treat cancer have been dismissed by conventional cancer experts. The new US investigation led by Dr Qi Chen, from the National Institutes of Health in Bethesda, Maryland, involved testing the effects of vitamin C on laboratory cell lines and cancer-ridden mice. In the laboratory, two hours of exposure to the vitamin significantly reduced the survival of ovarian, pancreatic and brain tumour (glioblastoma) cancer cells. Similar results were seen when mice bearing the same kinds of tumours were injected with vitamin C.

Independent.ie

Walk Off High Blood Pressure

Did you know that just five minutes exercise twice a week can help reduce blood pressure? Doctors in the US have found that simple lifestyle changes can prevent normal blood pressure from becoming high blood pressure. They also found that even small amounts of exercise can significantly lower blood pressure. According to the researchers, moderate exercise intensity, such as a brisk walk or slow jog, is more effective in lowering blood pressure than higher intensity.

The doctors advise that starting with small amounts of an exercise which you enjoy, slowly increasing duration by one or two minutes each week, and then gradually building up to 100 to 200 minutes of exercise. Previous research has shown that sedentary or "couch potato" individuals are at almost double the risk of developing hypertension compared to people that are physically active.

Healthy You

Rural, Unmarried Women at Higher Risk for Depression

Mayo Clinic research suggests unmarried women living in rural areas have lower self-rated health status than their married counterparts.

This lower health status often includes greater instances of self-assessed feelings of depression. The results of the study were recently published in the Journal of Evaluation in Clinical Practice. They suggest that primary care physicians should take a proactive role in addressing health concerns of single women. "We tend to focus on disease, but as the World Health Organization notes, good health includes physical, mental and social well-being and not merely the absence of disease," says James Rohrer, Ph.D., of Mayo Clinic's Department of Family Medicine and lead author of the study. "Being single may be associated with a greater degree of separation from usual health care, as many women gain insurance through a spouse or a former spouse. Lack of social support also may contribute to poor health among some single women."

Researchers used a cross-functional survey to gather self-ratings of overall health among female primary care patients aged 18 years and older who live in cities with a census of approximately 3,000. The study analyzed marital status and self-assessed mental health as potential risk factors for poor overall self-rated health among female primary care patients. The analysis revealed that single or divorced women are more

prone to poor self-rated health compared to married women. Women who described themselves as being depressed also had worse overall health. Women aged 65 and older had an even higher risk of poor self-rated health. While the data were finalized in 2000, Dr. Rohrer notes that current economic concerns may exacerbate the risk.

"Economic problems increase feelings of emotional stress. People today are worried about, among other things, the mortgage crisis and high gas prices. Many are left wondering how they are going to pay for necessities. Statistically, rural, unmarried women are more often economically depressed than their married counterparts," says Dr. Rohrer. "If the economy worsens, we will see a significant impact on visits to primary care physicians and nurses. Medical providers are trained to focus on the biological and psychological. But economic causes of poor health? I don't think that receives a lot of air time in medical school." Patients experiencing feelings of poor self-rated mental health can address these concerns with screening, health promotion and treatment programs. Screening can be followed-up with self-help materials, support groups and medication if deemed appropriate by the physician. Referrals to financial counselling might have indirect therapeutic value.

News-Medical.Net

"All of our dreams can come true – if we have the courage to pursue them."

Walt Disney

The Good and Bad Side of Dopamine

The chemical dopamine induces both desire and dread, according to new animal research in the July 9 issue of The Journal of Neuroscience.

Although dopamine is well known to motivate animals and people to seek positive rewards, the study indicates that it also can promote negative feelings like fear. The finding may help explain why dopamine dysfunction is implicated not only in drug addiction, which involves excessive desire, but in schizophrenia and some phobias, which involve excessive fear. "This study changes our thinking about what dopamine does," said Howard Fields, MD, PhD, of the University of California, San Francisco, an expert unaffiliated with the study. "There is a huge body of evidence out there to support the idea that dopamine mediates positive effects, like reward, happiness, and pleasure. This study says, it does do that, but it can also promote negative behaviours through actions in an adjacent brain area,"

Kent Berridge, PhD, and his colleagues at the University of Michigan, identified dopamine's dual effect on the nucleus accumbens, a brain region that motivates people and animals to seek out pleasurable rewards like food, sex, or drugs, but is also involved in fear. They found that inhibiting dopamine's normal function prevented the nucleus accumbens neurons from inducing both rewarding and fearful behaviours, suggesting that dopamine is important in both. In previous research, Berridge and colleagues showed that a distance of only a few millimetres separated desire and dread functions in the nucleus accumbens (which is only about 5 millimetres long in humans). Because dopamine is an important neurotransmitter in this brain structure, the researchers investigated its role in generating these functions in the current study.

When dopamine was allowed to act normally, injection of a chemical to model normal signalling in the front of the nucleus

accumbens caused rats to eat nearly three times as much as they normally do. In contrast, injection of the chemical in the back of the nucleus accumbens caused rats to display fearful behaviour normally shown in response to a predator. "It has always been assumed that discrete neurotransmitters might separate fear from desire, but this report shows that transmitters such as dopamine play a constant role and that the anatomy is providing for emotional discretion," said Peter Kalivas, PhD, at the Medical University of South Carolina, who was unaffiliated with the study. Berridge speculates that disruption of dopamine neurotransmission in one region of the nucleus accumbens may be a mechanism for pathological excesses of fear in disorders such as schizophrenia, whereas disruptions in dopamine neurotransmission in an adjacent region may be a mechanism for excessive reward-seeking in conditions like addiction.

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Misconceptions about Mental Illness – Pervasive and Damaging

MYTH 1: Psychiatric disorders are not true medical illnesses like heart disease and diabetes. People who have a mental illness are just “crazy”.

FACT: Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows genetic and biological causes for psychiatric disorders, and they can be treated effectively.

MYTH 2: People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.

FACT: Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened, confused, and despairing than violent.

MYTH 3: Mental illness is the result of bad parenting.

FACT: Most experts agree that a genetic susceptibility, combined with other risk factors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.

MYTH 4: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.

FACT: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people recover.

MYTH 5: Schizophrenia means split personality, and there is no way to control it.

FACT: Schizophrenia is often confused with multiple personality disorder. Actually, schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.

MYTH 6: Depression is a normal part of the aging process.

FACT: It is not normal for older adults to be depressed. Signs of depression in older people include a loss of interest in activities,

sleep disturbances, and lethargy. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

MYTH 7: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.

FACT: Children and adolescents can develop severe mental illnesses. In the United States, 1 in 10 children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20% of these children receive needed treatment. Left untreated, these problems get worse. Anyone talking about suicide should be taken very seriously.

MYTH 8: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way “failed” or is weak.

FACT: A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

MYTH 9: Addiction is a lifestyle choice and shows lack of willpower. People with a substance abuse problem are morally weak or “bad”.

FACT: Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a “bad” person.

MYTH 10: Electroconvulsive therapy (ECT), formerly known as “shock treatment” is painful and barbaric.

FACT: ECT has given a new lease on life to many people who suffer from severe and debilitating depression. It is used when other treatments such as psychotherapy or medication fail or cannot be used. Patients who receive ECT are asleep and under anaesthesia, so they do not feel anything.

National Alliance for Research on Schizophrenia and Depression, research newsletter

“Whatever you fear most has no power; it is your fear that has the power.”

Anonymous

Study Shows Promising Results in Deep Brain Stimulation for Treatment-Resistant Depression

New data from a study of patients with treatment-resistant depression who underwent deep brain stimulation (DBS) in the subcallosal cingulate region (SCG or Cg25) of the brain shows that this intervention is generally safe and provides significant improvement in patients as early as one month after treatment. The patients also experienced continued and sustained improvement over time. The data are reported in the online issue of *Biological Psychiatry*. This clinical trial is the culmination of 20 years of research using brain imaging technology that has worked to characterize functional brain abnormalities in major depression and to identify the mechanisms of various antidepressant treatments.

A report on the first six patients in the study was published in the *Journal of Neuroscience* in 2005. The new paper reports on an expanded sample of patients and an extended period of clinical follow-up. DBS uses high-frequency electrical stimulation targeted to the specific areas of the brain involved in neuropsychiatric disease. Twenty patients received SCG DBS for 12 months. Twelve of 20 patients experienced a significant decrease in depressive symptoms (defined by a 50 percent decrease in the Hamilton Depression rating scale) by six months, with seven patients essentially well with few remaining symptoms (remission,

defined as a Hamilton Depression Rating Scale score <8). Benefits were largely maintained at 12 months with continued stimulation. No long-term side effects were reported.

Each study patient was implanted with two thin wire electrodes (one on each side of the brain) in the white matter adjacent to SCG. The other end of each wire was connected under the skin of the neck to a pulse generator implanted in the chest – similar to a pacemaker – that directs the electrical current. The researchers regulated the intensity of the current according to the response of the patient. Only patients who were unable to get better with most other types of antidepressant treatment – including medication, psychotherapy and electroconvulsive therapy – were included in the study. In previous studies using brain imaging, we found the subcallosal cingulate region was a key region in an emerging emotion regulation circuit implicated in major depression.

It was postulated that if stimulation worked for the treatment of other neurological disorders where abnormal function of specific circuits was well established, such as Parkinson’s disease, then stimulation of the Cg25 region within this apparent depression circuit might provide significant benefit for patients with treatment-resistant depression.

The researchers were able to track the clinical response of the patients over a 12-month period using standard depression rating scales as well as various quantitative measures of behavior and general functioning, neuropsychological testing and scanning of both regional brain blood flow and glucose metabolism using positron emission tomography (PET).

PET imaging of these patients demonstrated that metabolic activity changed locally at the site of stimulation but also throughout the previously identified depression network, providing evidence that modulating the circuit and not just a single region was likely responsible for the antidepressant effects. They see depression as a complex disturbance of the specific circuits in the brain responsible for regulating mood and emotions. They hypothesized that if DBS could locally modulate a critical central location within this mood circuit, such modulation would result in clinical improvement – and it appears it does.

News-Medical.Net

“If you can dream it, then you can achieve it. You will get all you want in life if you help enough other people get what they want”.

Flickr

Depression Still a Taboo Subject

The majority of people still do not feel comfortable discussing depression with a doctor, according to new research. According to the results of the Lundbeck Mental Health Barometer report, 60 per cent of people think depression is a difficult condition to discuss with a doctor and only 71 per cent would consult a GP if someone they knew was suffering from depression – a drop of almost 10 per

cent from 2007. When surveyed, those with personal experience of the condition reported death and suicide, low self-esteem and sleep disturbances as the most common symptoms, being cited by 32 per cent, 29 per cent and 28 per cent respectively.

Irish Medical Times

Depression

Most of us have had times when we have been down. We have all been unhappy. Some of us will have had depression. Depression is an illness when the sadness has gone too far. Depression can look like ordinary unhappiness. The difference is the effect. If you're unhappy you may look miserable and cry, but you can probably still go out. You might not feel like it, but with an effort you can do the things you usually do. You can even cheer up for a bit. Other people know that, and they try to take you out of yourself.

With depression, this doesn't always work. She doesn't laugh at your jokes anymore. She doesn't notice the flowers when you go for a walk. Or more likely she won't even go for a walk. As she sits about doing nothing, you might get angry. It's easy to think that she is not making an effort. She may say you don't know how she feels.

She feels terrible. Nothing has any point anymore. Everything that mattered is meaningless. Partners, work, children - everything she felt passionate about is like nothing. She takes no pleasure. She sees no joy. Nothing she does seems to change it. She tries to do something but it doesn't work out. She forgets the cake and burns it. She can't think of anything to say to her friends. She knows it's not right but she doesn't know what's wrong except that it is her fault. She isn't being a good person. She is letting everyone down. She cannot imagine it ever changing. She feels helpless and hopeless. She may even completely despair.

People who are depressed sometimes take their own lives. One thing they say is that they feel everyone would be better off without them. That's where they are wrong. Caring for someone who is depressed can be hard. But it is not as bad as she imagines it is. A person who isn't pulling her weight can feel like a burden. But that is not for her to decide. Those close to her are the ones to say when it is too much. When it gets too much for everyone there is always help. Other friends, other people, professionals. Depression can be treated.

1. Depression

This young girl went to bed last night and prayed she wouldn't wake up. She did. At four in the morning. It is still the middle of the night. She can't go back to sleep. What is she doing? Often people with depression wake early in the mornings. It is then that they feel at their worst. The day ahead seems unbearable. Everything is such a struggle. They feel like a waste of space. If this goes on she might think that everyone would be better off without her. She might try to take her own life. She might even succeed. It doesn't have to be that way. Depression is a curable illness.

2. Depression

This man has been looking at this clock all morning. And as far as he can tell it hasn't moved. What is he doing? Sometimes people with depression feel like they can't do anything. The world just grinds to a halt. All they see is endless hours. Hours of doing nothing. Hours of feeling nothing. Hours of being nobody. If this gets really bad, he might stop eating and drinking. He could even just turn his face to the wall and die. Fortunately there are effective treatments for this.

3. Depression

This man has been watching football all evening. But if you ask him he has no idea who has scored. What is he doing? People with depression have trouble concentrating. They say they don't enjoy things as they used to.

They can't follow what's going on. They do things wrong like forgetting to buy the milk. People around them can find this annoying.

Why doesn't he pull himself together? Is he just feeling sorry for himself? Wouldn't you if everything seemed pointless? If you took no pleasure in anything at all? Your family, your work, your mates? Football?

4. Depression

This woman's friend has just asked her how she is. She has just burst into tears. What is she doing? People with depression feel sad. They may cry. They may not be able to say why. They may say they don't understand it. They may have got everything they could ever want. This is hard for the woman and her loved ones. It is difficult to understand why she is unhappy when there is no need for it. She has got the house, she has got the baby, friends, money, people who love her. What's there to be upset about? Often there is not any one thing. There may be many - stress, worry, tiredness, problems from the present or the past. Giving no reason does not mean there is no cause.

5. Depression

It is three in the morning and he hasn't got a home to go to. He's got a place to sleep. But he says he's never had a home or, rather, he's had too many. His Mum's, his foster parents', that children's place, his other foster parents', the army. Until he got kicked out. He cut his wrists. Or was it an overdose? He's hurt himself that many times he's lost track. Depression affects people in different ways. Some people become self-destructive. They drink too much, drive too fast, get into fights and dangerous relationships. And they harm themselves. Others say it's just a cry for help. People who really kill themselves don't tell anyone about it. Maybe they do, but no-one is listening.

FACTS ABOUT DEPRESSION

What is depression?

When people are severely depressed, they feel that life has little to offer them and that things will never get better. This low mood is more than being fed-up or unhappy. We can all feel sad from time to time, especially after a recent loss or for no reason at all.

Depression is an illness that can be treated and should not be ignored. With skilled help and the chance to talk, most people will recover after several months. For others it may take longer and the depression may return. Occasionally people feel so hopeless that they think about, or even commit, suicide.

In manic depression or bipolar affective disorder, people will suffer not only from episodes of depression, but also episodes of mania. At these times a person's mood becomes very 'high' and there will be a change in behaviour. The person who is ill may act recklessly, for example spending lots of money and running up large debts.

Who suffers from depression?

At least one person in five will suffer from a depressive illness at some point in their life. It appears to be more common in women than men because women are more likely to seek help than men. It occurs at any age, even in children and young people. Bipolar affective disorder is less common affecting one person in 100 and affects both men and women.

What causes depression?

There are a number of reasons why people become depressed. These may include: reactions to life events and stresses, and genetic or biological factors. Early experiences in life and losses through bereavement or the break-up of a relationship may trigger episodes of depression, and perhaps mania. A number of physical illnesses are also linked with depression, such as infections like influenza, and disorders of the thyroid gland.

Family studies suggest that manic depression in particular sometimes runs in families. There may be an abnormality in brain biochemistry involving a chemical messenger called serotonin.

What treatments are available?

In a mild episode of depression a person may find that, with support from family or friends, the symptoms improve by themselves. Talking through problems can help resolve any life stresses that may have caused the illness. If the symptoms persist for more than two weeks, people may need to seek professional advice, initially from their family doctor.

There are a number of ways of treating depression. Medication with antidepressants can help relieve the symptoms and prevent future episodes. The drugs work by acting on the chemical messengers in the brain. Talking therapies such as relationship based psychotherapy can be useful; also problem-solving therapies and cognitive therapy in which the therapist, often a psychologist, helps a person learn to identify and challenge faulty, negative patterns of thinking. Support from family and friends is vital. Other activities, such as regular exercise, can help lift the depression.

If the symptoms do not improve, or a person feels suicidal, the family doctor may refer the individual to a specialist mental health team. Members of the team will have a range of skills which enable them to make a full assessment of a person's background, social, psychological and living skills, in order to understand their problems and to formulate a treatment plan. The team may be able to offer more intensive support at home, and if needed, hospital admission. The person with depression can help himself by learning how to relax, to do the things he enjoys and by taking exercise. If he learns about his symptoms and what makes them better or worse, he can learn to control them. He can also see that they do not last forever, which can help him to feel more hopeful about the future.

What can society do?

Public education can help us to have a better understanding of the nature of depression. With this understanding should come increased tolerance. We need to understand that depression and manic depression are more than ordinary feelings of unhappiness. They can have a major effect on someone's ability to carry on with day to day living. People with these disorders, and their families, need support in seeking help and getting treatment. Educating employers about depression and the way it affects a person's ability to work, should improve opportunities for training and employment. Better social conditions, such as improved housing and lower levels of unemployment, would help reduce some of the environmental stresses people experience.

The Royal College of Psychiatrists

Research Links Smoking To Poor Memory in Middle Age

Smoking is associated with an increased risk of poor memory and a decline in reasoning ability in middle age, research published today suggests. The results of the study are considered important because individuals with cognitive impairment in midlife may progress to dementia at a faster rate.

Severine Sabia and her colleagues from the Institute National de la Santé et de la Recherche Médicale, France and the Department of Epidemiology and Public Health, University College London, analysed data from 10,300 civil servants who participated in the Whitehall II Study. The major study recruited London-based civil servants aged 35-55 between the years 1985 and 1988 and since then has periodically tested them for a wide range of health indicators. For this study, some 4,500 participants completed tests of memory, reasoning, vocabulary and verbal fluency between 1997 and 1999, while just over 4,600 were re-tested five years later. During the first round of cognitive testing, those who smoked were more likely to be in the lowest performing group for memory and reasoning compared with those who had never smoked.

There was good news for those who were former smokers at the beginning of the study. They were 30 per cent less likely than smokers to have poor vocabulary and low verbal fluency scores. And those who stopped smoking during the study were more likely to drink less alcohol, be physically active and eat more fruit and vegetables. Writing in the latest issue of Archives of Internal Medicine, the authors say the study has a number of key findings. "First, smoking in middle age is associated with memory deficit and a decline in reasoning abilities. Second, long-term ex-smokers are less likely to have cognitive deficits in memory, vocabulary and verbal fluency. Third, giving up smoking in midlife is accompanied by improvement in other health behaviours."

However, the researchers caution that, although the study was a large and prospective one, the data are from white-collar civil servants and cannot be assumed to apply to the general population. "During the past 20 years, public health messages about smoking have led to changes in smoking behaviour," Ms Sabia and her colleagues note. "Public health messages on smoking should continue to target smoking of all ages." Last year, research combining the results of a number of key studies (a meta analysis) concluded that smoking is a risk factor for dementia. While this study confirms a risk link between smoking and poor memory and reasoning ability, there is insufficient evidence to allow conclusions to be made about an association between smoking and specific cognitive tasks. A link between smoking and poorer cognition is most likely a reflection of the effect smoking has on atherosclerosis, the "furring up" of arteries in the brain and other parts of the body. Commenting on the results, a spokeswoman for Ash Ireland, the anti-smoking lobby group, said: "This article illustrates yet another good reason to stop smoking and that it is never too late to do so."

Irish Times, Health Supplement

Suicide Prevention: What can we do? - as people, as pharmacists.

A report by a pharmacist from Preventing Suicide across the Lifespan: Dreams and Realities, an international conference held in Killarney, Co Kerry, September 2007

Anyone who works with me will know I'm not a morning person. But it would be churlish of me to complain about getting out of bed for the 8:30am opening ceremony for the five-day international conference on suicide prevention, Preventing Suicide across the Lifespan: Dreams and Realities, only to be greeted by half an hour of jigs and reels. The night before we'd been well entertained at a reception, hosted by the Irish Association of Suicidology (IAS), to welcome the 695 delegates from 45 different countries to Killarney. The night had ended in a sing-along with entertainer Frances Black and set an upbeat tone for a conference with a grim sound but a positive message: suicide prevention. Because of course, the emphasis is on prevention. The people attending this conference all had and have one goal: to make life worth living for every single person. Every person who is not reached, and not persuaded that life is worth living, is not seen as merely a statistic, but a sad loss.

President Mary McAleese, a patron of the IAS, addressed the conference on the Friday and she expressed the hope that we could become a more caring and sensitive society, where people take care of their own mental health and that of others. She said we need to create a society where people seek help and do not retreat. She compared the conference to the teams that work in scientific research on genes - when information is pooled and shared, people discover that they hold pieces of a jigsaw and that others hold other pieces, that, coming together, form a whole picture. In her speech she mentioned some of the factors contributing to the suicide rate in Ireland and all over the world, in particular how drugs such as alcohol and cannabis increase the risk of depression and how we need to decrease acceptance of these forms of self-abuse. She also emphasised the need to need to protect people from bullying and the subsequent

downward spiral, and the need to cultivate acceptance of all sexualities, as, she pointed out, homosexuality is a discovery and not a decision.

Based on the work of the subsequent National Task Force on Suicide in Ireland and the National Suicide Review Group, the Government has come up with a strategic framework to tackle the suicide problem in Ireland. Reach Out is the national strategy for action on suicide prevention, and recommends a number of measures to be taken by various agencies and groups "in order to effect real change over the next 5 to 10 years". There is general agreement about routes to suicide prevention. The approach is fourfold: a general population approach to promote positive mental health; a more targeted approach towards high risk groups and vulnerable people; an improved response to suicide so as to minimise distress to families and communities; and improved access to information and research.¹⁾

The conference covered all these issues and the various experts shared tactics and results. Raising an issue I had not considered, Dr Greg Carter of the Australian University of Newcastle pointed out the problems in this field of generating statistics and running trials to test if a suicide prevention method works. This problem was widely acknowledged in nearly every presentation. For research to be done, a researcher needs proof of evidence and statistics, and the field of suicidology as an academic subject is no different.

So what can we do, as pharmacists?

Pharmacists are specifically mentioned in Reach Out as they have an important role in monitoring the mental state of those who come in to the pharmacy, and also in monitoring any harmful use of

medications. The DUMP (Dispose of Unused Medicines Properly) campaign should be promoted for disposing of any unused medication. DUMP was launched in 2002 and was reviewed in a poster presented at the conference. The research team found that a large proportion of returned drugs corresponded with those commonly associated with suicide and deliberate self-harm.² In an Irish study on suicidal behaviour in children and adolescents it was found that 81% use overdosing as their method of choice for suicide, paracetamol overdose being the most common. DUMP has so far proved to be a successful campaign and surely the regulations relating to the sale of paracetamol also play a useful part in suicide prevention.

Reach Out specifically mentions that a programme of education and training on suicide prevention should be delivered for all relevant members of the primary care team, including community pharmacists, and that awareness building relating to suicide prevention and mental health promotion should be extended to pharmacists, given the level of contact between pharmacists and (health) service users.

Another issue for pharmacists is how we approach the care of our patients with depression, especially those to whom we dispense antidepressants. I believe that it is our responsibility to take the potential side effect of SSRIs of suicidal ideation extremely seriously. Drug companies have admitted the severity and extent of the effect and no longer recommend these drugs for use in those under 18 years of age, but of course the problem is not limited to younger patients. The most dangerous time, according to manufacturers, is when a person begins or ends antidepressant treatment. The effect, however, is ongoing so we must make sure that no matter how long a person has been

on the treatment, they are aware of the potential for this side effect. It is all too easy to dismiss the tragedy of a suicide of a person on antidepressants as the disease and not the drug. If we let ourselves believe this we are uninformed and not fulfilling our responsibility as pharmacists. The attitude is all too common in psychiatric prescribing. A study of prescribing practices of psychiatrists after the FDA's issue of a blackbox warning for "suicidality" for all antidepressants prescribed to children and adolescents, was undertaken in the Mayo Clinic in the U.S. 92% of psychiatrists reported no change in their prescribing patterns.⁴ It is therefore our responsibility to make sure the patient is forewarned, and taken seriously.

In his plenary address, Professor Ad Kerkof, Dept of Clinical Psychology, Vrije Universiteit, stated that: "Suicide and attempted suicide are mostly the result of long term processes in which distress and despair culminate into hopelessness, worrying, sleeplessness, emotional desperation, and the typical suicidal constriction of the mind. Even when patients are being treated for depression or for other emotional disorders, many do not contact their health care provider when suicidal: they feel ashamed; they consider their problems to be insurmountable, they don't expect the health care system to be able to help them, or they consider themselves to be intractable cases." Pharmacists can aim to lower this level of shame and feeling, by voicing concern.

Coping mechanisms

There were many presentations at the conference on the value of cognitive behavioural therapy in the treatment of people with depression. Reach Out points out that suicidal people can have a "collapse in behavioural and cognitive repertoires that would normally support problem solving," and suggest that treatment should be aimed to develop cognitive and behavioural skills to manage

suicide ideation. Greg Carter pointed out in his plenary talk that suicidal ideation can be acute, but extremely short-lived. He gave the example of a survivor who jumped off the Golden Gate Bridge. He regretted his choice to kill himself while on the way down to the water. In his plenary session, Prof. J.M.G. Williams of Oxford explained how vulnerability to suicidal ideation consists in the ease with which small downward shifts in mood lead to complete hopelessness.⁵ One presentation discussed the effects of teaching problem solving.⁶ Another discussed the value of a "hope box," a physical box in which a patient would put reminders of things that make life worth living.⁷ The solidity of a small box, something one can hold in one's hand, is meant to help in reducing feelings of hopelessness, and provide a distraction, to stem the spiral of acute hopelessness. Another tool is a "coping card" which has a familiar key automatic thought on one side, and an adaptation response on the other.

Interventions

Several training programmes to provide interventional skills training were described at the conference. The ASIST programme provides basic intervention skills training. Run by the National Youth Health Programme, it is aimed to prevent suicide of young people. Another current prevention programme is STORM, Skills Based Training on Risk Management, a programme for frontline workers in health, social and criminal justice services in the UK and Ireland. The STORM package comprises four flexible modules covering Assessment, Crisis Management, Problem Solving and Crisis Prevention. Each module uses role-rehearsal, feedback and self-reflection to develop micro-skills. STORM is important because in the session dedicated to discussion of suicide prevention in Ireland and the UK it was reported that 42% of health professionals admitted to being uncomfortable in dealing with a seriously suicidal patient.

The most exciting training programme which I learned about at the conference, which is most relevant to pharmacists, is a programme set up by the European Alliance Against Depression, which was established in April 2004. They are running programmes to train community facilitators in skills of suicide prevention, and they see pharmacists as a possible target group for training to be community facilitators (CF's). CF's are envisaged to be people who come into contact with people suffering from depression or suicide ideation, such as teachers, policemen, prison officers, social workers, geriatric caregivers, and the clergy, as well as pharmacists. They could play an important role in decreasing stigmatisation and in providing a first point of detection, supportive services, and referral to adequate mental health treatment. Training focuses on basic knowledge and skills in dealing with depression and suicide. So far, the EAAD have run some training programmes in Ireland, but none yet for pharmacists, although they have trained 429 pharmacists in other countries. I spoke to Dr. Ella Arensman, Director of Research at the National Suicide Research Foundation, after the presentation and expressed my special interest in this programme.

Where to get help

Throughout the conference, information about various support groups was available in the lobby. For me, this was one of the most helpful aspects of the conference. One of the best things pharmacists could do to play a role in suicide prevention is to be well-informed on sources of help available for suicidal people.

List of references available from the IAS office

By Jennifer Baggot MPSI

"A kind heart is a fountain of gladness, making everything in its vicinity freshen into smiles."

Washington Irving

Death by hanging is most prevalent form of suicide

Hanging is the most common method of suicide in Ireland for both males and females, according to new research. A study, published in the Journal of Epidemiology and Community Health, found that 60.2 per cent of Irish male suicides and 33.4 of female suicides were the result of hanging. The second most prevalent method of suicides in Ireland was drowning for males (16.1 per cent) and poisoning by drugs for females (28.1 per cent).

Irish males were much less likely to take their own lives with drug overdose, with the research stating that only eight per cent took their lives through the method. On the basis of its findings, the study argues for gender-specific interventions for suicides based upon research into common methods people use to take their own lives. Data collected from 16 European countries participating in the

European Commission funded project "European Alliance Against Depression" from the years 2000 to 2004/5. For males, hanging was followed by firearms (9.7 per cent) and poisoning by drugs (8.6 per cent), while for females by poisoning by drugs (24.7 per cent) and jumping from a high place (14.5 per cent).

Death by firearms only accounted for 7.6 per cent of Irish male suicides and 1.9 per cent of Irish female suicides. Although not employing any gender-specific interventions, project co-ordinator at Pieta House, Centre for Prevention to Self-Harm or Suicide, Mr. Michael Tighe said that removing the means of access to potential suicide methods can be beneficial preventing suicides.

Irish Medical News

Energy Drinks Associated With Risk-Taking Behaviours Among College Students

Over the last decade, energy drinks - such as Red Bull, Monster and Rockstar - have become nearly ubiquitous on college campuses. The global market for these types of drinks currently exceeds \$3 billion a year and new products are introduced annually.

Although few researchers have examined energy drink consumption, a researcher at the University at Buffalo's Research Institute on Addictions (RIA) has been investigating links between energy drinks and public health concerns like substance abuse and risky behaviors.

Two new research reports by (RIA) Research Scientist Kathleen E. Miller, Ph.D., examine the relationships between energy drink consumption and risk-taking in college students as well as "toxic jock identity" -- characterized by hyper-masculinity and risk-taking behaviors among college-age athletes.

Dr. Miller's research validates and expands upon existing concerns about energy drink consumption: "The principal target demographic for energy drinks is young adults ages 18-25, but they're nearly as common among younger teens," she explains. "This is a concern because energy drinks typically contain three times the caffeine of a soft drink, and in some cases, up to 10 times as much. They also include ingredients with potential interactions such as taurine and other amino acids, massive doses of vitamins, and plant and herbal extracts."

In the first set of results published online in June in the Journal of Adolescent Health, Miller identified links between energy drink consumption, risky substance use and sexual risk-taking.

Frequent energy drink consumers (six or more days a month), according to Miller's findings, were approximately three times as likely than less-frequent energy drink consumers or non-consumers to have smoked cigarettes, abused prescription drugs and been in a serious physical fight in the year prior to the survey. They reported drinking alcohol, having alcohol-related problems and using marijuana about twice as often as non-consumers. They were also more likely to engage in other forms of risk-taking, including unsafe sex, not using a seatbelt, participating in an extreme sport and doing something dangerous on a dare. The associations with smoking, drinking, alcohol problems and illicit prescription use were found for white but not African-American students.

A total of 795 Western New York male and female undergraduate students participated in the study and 39 percent reported consuming at least one energy drink in the previous month. There was significantly higher consumption by men (46 percent) than by women (31 percent) and higher consumption by whites (40 percent) than by blacks (25 percent). Eighty-seven percent of the students in the study were white; 52 percent were male.

Two-thirds of the energy drink consumers in Miller's study had used energy drinks as mixers with alcoholic beverages. The growing popularity of this practice further heightens concern, Miller says.

"It is widely, but incorrectly, believed that the caffeine in energy drinks counteracts the effects of alcohol, so students will have the energy to party all night without getting as drunk," she explains. "While the combination may reduce perceptions of intoxication, it does not reduce alcohol-induced impairments of reaction time or judgment."

According to Miller, these findings suggest that frequent energy drink consumption may serve as a useful screening indicator to identify students at risk for what scientists call "problem behavior syndrome."

"Energy drink consumption is correlated with substance use, unsafe sexual activity and several other forms of risk-taking," Miller notes. "For parents and college officials, frequent energy drink consumption may be a red flag or warning sign for identifying a young person at higher risk for health-compromising behavior."

"Although energy drink consumption can be used to predict other problem behaviors, it does not necessarily follow that drinking these substances is a gateway to more serious health-compromising activities," Miller cautions. "It is entirely possible that a common factor, such as a sensation-seeking personality or involvement in risk-oriented peer sub-cultures, contributes to both. More investigation is needed to study these relationships further, over longer periods of time."

News-Medical.Net

Workplace Bullying

While bullying is a form of aggression, the actions can be both obvious and subtle. It is important to note that the following is not a checklist, nor does it mention all forms of bullying. This list is included as a way of showing some of the ways bullying may happen in a workplace. Also remember that bullying is usually considered to be a pattern of behaviour where one or more incidents will help show that bullying is taking place.

Workplace bullying is repeated, unreasonable behaviour directed toward an employee, or group of employees, that creates a risk to health and safety.

What are examples of bullying?

- spreading malicious rumours, gossip, or innuendo that is not true
- excluding or isolating someone socially
- intimidating a person
- undermining or deliberately impeding a person's work
- physically abusing or threatening abuse
- removing areas of responsibilities without cause
- constantly changing work guidelines
- establishing impossible deadlines that will set up the individual to fail
- withholding necessary information or purposefully giving the wrong information
- making jokes that are 'obviously offensive' by spoken word or e-mail
- intruding on a person's privacy by pestering, spying or stalking
- assigning unreasonable duties or workload which are unfavourable to one person (in a way that creates unnecessary pressure)
- underwork - creating a feeling of uselessness
- yelling or using profanity
- criticising a person persistently or constantly
- belittling a person's opinions
- unwarranted (or undeserved) punishment
- blocking applications for training, leave or promotion
- tampering with a person's personal belongings or work equipment.
- Practical jokes
- Being sworn at
- Someone insulting you
- Being excessively supervised
- Being constantly criticised
- Being put down in public
- Rumours being spread about you
- Being overloaded with work or not given enough work to do
- Not getting the information you need to do your job
- Your personal effects or work equipment being damaged
- Being threatened with termination

Parents in Plea to Tackle Primary Bullies

Some children who enjoyed a carefree summer are going back into a situation of "intimidation and hurt" in school, the National Parents Council (Primary) claimed recently. It made an urgent call to schools and parents to work together to help prevent bullying in primary schools. They should take preventative measures to reduce the incidence of bullying occurring and to empower children to tell an adult they trust if they find themselves in a bullying situation. The council said that bullying was the single biggest issue raised on its Helpline and was the subject of more than 300 calls from parents in the last school year. It is seeking volunteers to help provide a new service early next year for parents whose children have been subjected to bullying.

Responsibility

It said parents should talk to their children in an age-appropriate manner regarding bullying to ensure children have clear messages before a potential bullying situation arose. School measures should include parents and children, reviewing and renewing the school anti-bullying policy. They should also involve:

- Awareness building in the school regarding positive behaviour and unacceptable behaviour.
- The whole school community taking responsibility for identifying and reporting incidences of bullying.
- A policy and support programme should be in place for a child who has been the victim of bullying behaviour.
- A policy and support programme should be in place for a child who has been exhibiting bullying behaviour.

The council said that bullying can only exist in an environment of fear and disempowerment; it is the responsibility of the adults in children's lives to inform and empower them to seek support when they need it. However, the Irish National Teachers' Organisation rejected the description of fear and intimidation as reflective of the general situation in schools. John Carr, the union's general secretary, said that a great deal had been done to tackle the problem with anti-bullying policies and the Stay Safe programme. He said that schools needed to be resourced to further improve the situation and class sizes needed to be reduced.

Independent.ie

"Empty pockets never held anyone back. Only empty heads and empty hearts can do that"

Norman V. Peale

8TH NATIONAL CONFERENCE

INNOVATIONS IN PREVENTING YOUTH SUICIDE

20th November '08
 Sheraton Hotel, Athlone, Co. Westmeath

This conference aimed at Principals, Teachers, Guidance Counsellors, Chaplains and everybody involved with young people and will address the following:-


- Growing up Gay
- Bullying and the Skills Necessary in Dealing with It
- Building Self-Esteem/Self-Worth Among Youth
- Adolescent Drug & Alcohol Misuse: Causes, Consequences & Treatment Options
- The Internet: Friend or Foe?
- What Young People Have To Say About Their Mental Health

Speakers will include: **Ms. Nicci Spinzola**, is the Director of the Adolescent and Family Services at **Richard Hall CMHC** in Bridgewater, NJ. **Padraig O'Morain**, Counsellor, Psychotherapist & author with Irish Times, **Dr Bobby Smyth**, Consultant Child & Adolescent Psychiatrist & Lecturer In Addiction Studies, Department of Public Health & Primary Care, TCD. **Daniel Sullivan**, Researcher in the area of Collaborative Practices in Software, Dublin, **Craig Hodges**, Director Service Development and **Nuala Smith**, Youth Participation Officer and a panel of six young people, Headstrong.

Conference fee: includes conference pack, two tea/coffee breaks, and lunch. Cost per delegate €120/£87. 10% reduction for IAS members

Special accommodation rates available from the Sheraton Hotel €70B&B per person sharing €110 single. Reservations must be made prior to 6th November '08 by contacting the hotel directly at: E-mail: reservations@sheratonathlonehotel.ie Tel: 090 6451000

Further information from the IAS office: 094 9250858 or visit our website: www.ias.ie



ias
The Irish Association of Suicidology

Registration Form

Innovations in Preventing Youth Suicide

Conference Fee of €120/£87 includes conference pack, tea/coffee breaks, lunch and a copy of the proceedings of the conference to be published in early 2009.

Conference Fee €120/£87

Single Membership €40/£29

Corporate Membership €200/£145 (up to 7 members)

10% discount for members

Total amount enclosed € / £ _____

Name: _____

Address: _____

Name of School: _____

Position Held: _____

Phone Number: _____ E-mail Address: _____

Application Form, which must include the appropriate conference fee (cheques to be made payable to the Irish Association of Suicidology) should be sent to **Ms. Josephine Scott, Executive Officer, 16, New Antrim St., Castlebar, Co. Mayo.**
 Tel. +353 (0) 94 9250858. Fax. +353 (0)94 9250859. e-mail: joscott@eircom.net
10% cancellation fee applies. Closing date for registration 13th November 2008. REFUNDS CANNOT BE GIVEN AFTER THIS DATE.

Why 37 days?

In October of 2003, my stepfather was diagnosed with lung cancer. He died 37 days later.

During that 37 days, I helped my mother care for him at home, since he wanted to die there. Never having been around someone dying before, I didn't know what to do. When my father died, I was just 19 and sitting in the intensive care waiting room. No one asked if I wanted to be with him; they just asked if I wanted to see him dead after it was all over. It was the beginning of a long realization of how intensively we avoid death, at least in this culture. But, back to 2003. It was at once profound and awkward, as if I were visiting in a place I ought not to be, hearing things I ought not ever hear, and dispensing morphine as if I knew how. He very soon lost the ability to speak, which made it both easier and harder. I was scared and anxious all the time, not knowing what was coming next. There was no manual that I could find, no prescription for what he was feeling and doing, how his insides were eating him up. I couldn't tell, and very soon into it, he couldn't tell me either.


Everything I could possibly think to talk to him about was so petty as to be painful. Would he like to watch a movie, I would pantomime? What? And have Hugh Grant be the last thing he might see on earth? The newspaper failed, the ads for supermarket bargains not relevant - but what was? At night, I could hear the oxygen machine making its move in and out as I waited for it to stop. And, finally, it did, after his feet started turning blue and we watched the blueness march

all the way up the 6-feet and 4-inches of him. The timeframe of 37 days made an impression on me. We act as if we have all the time in the world - that's not a new understanding. But the definite-ness of 37 days struck me. So short a time, as if all the regrets of a life would barely have time to register before time was up.

And so, as always when awful things happen, I tried to figure out how to reconcile in my mind the fact that it was happening and the fact that the only thing I could do was try to make some good out of it. What emerged was a renewed commitment to ask myself this question every morning: 'what would I be doing today if I only had 37 days to live?' It's a hard question some days.

But here's how I answered it: Write like hell, leave as much of myself behind for my two daughters as I could, let them know me and see me as a real person, not just a mother, leave with them for safe-keeping my thoughts and memories, fears and dreams, the histories of what I am and who my people are. Leave behind my thoughts about living the life, that "one wild and precious life" that poet Mary Oliver speaks of. That's what I'd do with my 37 days. So, I'm beginning here.

<http://37days.typepad.com/>



ias
The Irish Association of Suicidology

Membership Form

Name: _____

Address: _____

Present Position: _____

Work Telephone: _____ Work Fax: _____

E-mail Address: _____ Web Address: _____

Occupation: _____

Membership Fee: €40/£35stg

Cash

Cheque

Postal order

Please return to: **The Irish Association of Suicidology, 16 New Antrim St, Castlebar, Co. Mayo**