SAVING LIVES:

Understanding Depression And Suicide In Our Communities

Sponsored By The Ohio Department Of Mental Health In Partnership With The ADAMH Board Of Franklin County And The Ohio Suicide Prevention Team

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"Still the effort seems unhurried. Every 17 minutes in America, someone commits suicide. Where is the public concern and outrage?"

Kay Redfield Jamison

Author of *Night Falls Fast: Understanding Suicide*

Goals For Suicide Prevention

- Increase community awareness that suicide is a preventable public health problem
- Increase awareness that depression is the primary cause of suicide
- Change public perception about the stigma of mental illness, especially about depression and suicide
- Increase the ability of the public to recognize and intervene when someone they know is suicidal

Training Objectives

- Increase knowledge about the impact of suicide within the community
- Learn the connection between depression and suicide
- Dispel myths and misconceptions about suicide
- Learn risk factors and signs of suicidal behavior among community members
- Learn to assess risk and find help for those at risk – Asking the "S" question

Prevention Strategies

- General suicide and depression awareness education
- Depression Screening programs
- **Community Gatekeeper Trainings**
- Crisis Centers and hotlines
- Peer support programs
- Restriction of access to lethal means
- Intervention after a suicide

Suicide Is The Last Taboo – We Don't Want To Talk About It

- Suicide has become the Last Taboo – we can talk about AIDS, sex, incest, and other topics that used to be unapproachable. We are still afraid of the "S" word
- Understanding suicide helps communities become proactive rather than reactive to a suicide once it occurs
- Reducing stigma about suicide and its causes provides us with our best chance for saving lives
- Ignoring suicide means we are helpless to stop it

What Makes Me A Gatekeeper?

- Gatekeepers are not mental health professionals or doctors
- Gatekeepers are responsible adults who spend time with people who might be vulnerable to depression and suicidal thoughts
- Teachers, coaches, police officers, EMT's, Elder care workers, physicians, 4H leaders, Youth Group leaders, Scout masters, and members of the clergy and other religious leaders

Why Should I Learn About Suicide?

- It is the 11th largest killer of Americans, and the 3rd largest killer of youth ages 10-24
- As many as 25% of adolescents and 15% of adults consider suicide seriously at some point in their lives

- No one is safe from the risk of suicide – wealth, education, intact family, popularity cannot protect us from this risk
- A suicide attempt is a desperate cry for help to end excruciating, unending, overwhelming pain, sometimes called psychache (Schneidman, 1996)

Is Suicide Really a Problem?

- **81** people complete suicide every day
- **31,655** people in 2002 in the US
- Over **1,000,000** suicides worldwide (reported)
- This data refers to completed suicides that are documented by medical examiners – it is estimated that 2-3 times as many actually complete suicide

(Surgeon General's Report on Suicide, 1999)

The Unnoticed Death

- For every 2 homicides, 3 people complete suicide yearly– data that has been constant for 100 years
- During the Viet Nam War from 1964-1972, we lost 55,000 troops, and 220,000 people to suicide

Comparative Rates Of U.S. Suicides-2002

- Rates per 100,000 population
  - National average - 11 per 100,000*
  - White males - 19.9
  - African-American males - 9.1 **
  - Asians - 5.2
  - Caucasian females - 4.8
  - African American females - 1.5
  - Males over 85 - 67.6
- Annual Attempts – 790,000 (estimated)
  - 150-1 completion for the young - 4-1 for the elderly

(*AAS website),**(Significant increases have occurred among African Americans in the past 10 years - Toussaint, 2002)

Suicide Methods - 2002

Firearm suicides	17,108	54.0%
Suffocation/Hanging	6,462	20.4%
Poisoning	5,486	17.3%
Falls	740	2.3%
Cut/pierce	566	1.8%
Drowning	368	1.2%
Fire/flame	150	0.5%

(AAS website – 2005)

The Gender Issue

- Women perceived as being at higher risk than men
- Women do make attempts 4 x as often as men
- But - Men complete suicide 4 x as often as women
- Women’s risk rises until midlife, then decreases
- Men’s risk, always higher than women’s, continues to rise until end of life
- Are women more likely to seek help? Talk about feelings? Have a safety network of friends?
- Do men suffer from depression silently?

What Factors Put Someone At Risk For Suicide?

- Biological, physical, social, psychological or spiritual factors may increase risk-for example:
- A family history of suicide increases risk by 6 times
- Access to firearms – people who use firearms in their suicide attempt are more likely to die
- A significant loss by death, separation, divorce, moving, or breaking up with a boyfriend or girlfriend can be a trigger

(Goleman, 1997)

- Social Isolation: people may be rejected or bullied because they are "weird", because of sexual orientation, or because they are getting older and have lost their social network

- The 2nd biggest risk factor - having an alcohol or drug problem
  - Many with alcohol and drug problems are clinically depressed, and are self-medicating for their pain
  - Many older people take a lot of medication and may be unaware of the risks for altered mental state

(Surgeon General's call to Action, 1999)

- The biggest risk factor for suicide completion?

Having a Depressive Illness

- Someone with clinical depression often feels helpless to solve his or her problems, leading to hopelessness – a strong predictor of suicide risk
- At some point in this chronic illness, suicide seems like the only way out of the pain and suffering
- Many Mental health diagnoses have a component of depression: anxiety, PTSD, Bi-Polar, etc
- **90%** of suicide completers have a depressive illness

(Lester, 1998, Surgeon General, 1999)

Depression Is An Illness

- Suicide has been viewed for countless generations as:
  - a moral failing, a spiritual weakness
  - an inability to cope with life
  - “the coward’s way out”
  - A character flaw

- Our cultural view of suicide is wrong - invalidated by our current understanding of brain chemistry and it’s interaction with **stress, trauma and genetics** on mood and behavior

- The research evidence is overwhelming - depression is far more than a sad mood. It includes:

1. Weight gain/loss
2. Sleep problems
3. Sense of tiredness, exhaustion
4. Sad or angry mood
5. Loss of interest in pleasurable things, lack of motivation
6. Irritability
7. Confusion, loss of concentration, poor memory
8. Negative thinking
9. Withdrawal from friends and family
10. Sometimes, suicidal thoughts

(DSMIVR, 2002)

- 20 years of brain research teaches that these symptoms are the **behavioral** result of
  - **Internal changes in the physical structure of the brain**
  - **Damage to brain cells in the hippocampus, amygdala and limbic system**
  - **increased agitation in the limbic system**
- As Diabetes is the result of low insulin production by the pancreas, depressed people suffer from a physical illness – what we might consider “faulty wiring”

(Braun, 2000; Surgeon General’s Call To Action, 1999, Stoff & Mann, 1997, The Neurobiology of Suicide)

Faulty Wiring?

- Literally, damage to certain nerve cells in our brains - the result of too many stress hormones – cortisol, adrenaline and testosterone – the hormones activated by our Autonomic Nervous System to protect us in times of danger
- A situation of chronic stress causes a dysregulation or imbalance in the functioning of the ANS, so that a high level of activation occurs with very little stimulus
- We then see patterns of dysregulation in muscle tension, imbalances in blood flow patterns leading to certain illnesses such as asthma, IBS and depression

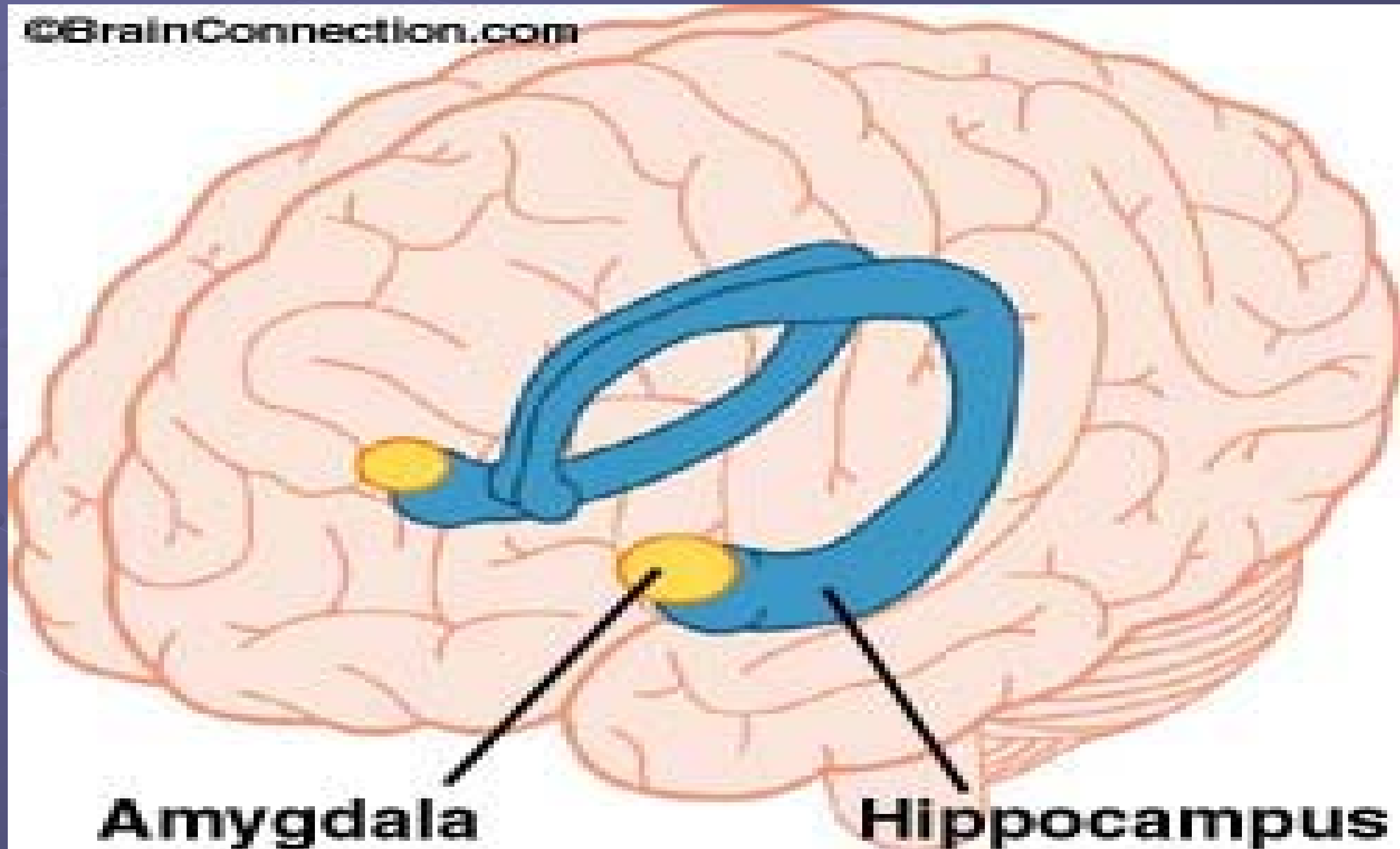
- (Braun, 1999)

Faulty Wiring?

- Without a way to detach and go back to a baseline of rest, hormones accumulate, doing damage to brain cells
- Stress alone is not the problem, but how we interpret the event, thought or feeling
- People with **genetic predispositions**, placed in a highly **stressful environment** will experience damage to brain cells from stress hormones
- This leads to the cluster of **thinking and emotional changes** we call depression

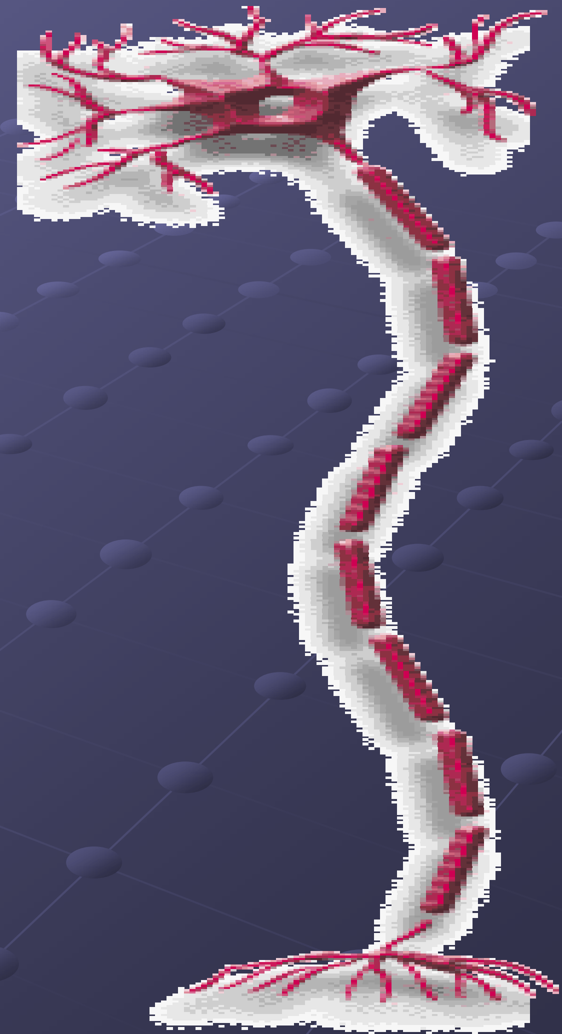
(Goleman, 1997; Braun, 1999)

Where It Hits Us



One of Many Neurons

- Neurons make up the brain and their action is what causes us to think, feel, and act
- Neurons must connect to one another (through dendrites and axons)
- Stress hormones damage dendrites and axons, causing them to “shrink” away from other connectors
- As fewer and fewer connections are made, more and more symptoms of depression appear



- As damage occurs, thinking changes in the predictable ways identified in our list of 10 criteria
- "Thought constriction" can lead to the idea that suicide is the only option
- How do antidepressants affect this "brain damage"?
- They may counter the effects of stress hormones
- We know now that antidepressants stimulate genes within the neurons (turn on growth genes) which encourage the growth of new dendrites

(Braun, 1999)

- Renewed dendrites:
  - increase the number of neuronal connections
  - allow our nerve cells to begin connecting again
- The more connections, the more information flow, the more flexibility and resilience the brain will have
- Why does increasing the amount of serotonin, as many anti-depressants do, take so long to reduce the symptoms of depression?
- It takes 4-6 weeks to re-grow dendrites & axons

(Braun, 1999)

How Does Psychotherapy Help?

- Medications may relieve immediate suffering and improve brain function, but do not change how we **interpret** stress
- Psychotherapy, especially cognitive or interpersonal therapy, helps people change the (negative) patterns of thinking that lead to depressed and suicidal thoughts
- Research shows that cognitive psychotherapy is as effective as medication in reducing depression and suicidal thinking
- Changing our beliefs and thought patterns alters our response to stress – we are not as reactive or as affected by stress at the physical level (Lester, 2004)

What Therapy?

- The standard of care is medication and psychotherapy combined
- At this point, only cognitive behavioral and interpersonal psychotherapies are considered to be effective with clinical depression (evidence-based)
- Patients should ask their doctor for a referral to a cognitive or interpersonal therapist

Possible Sources Of Depression

- Genetic: a predisposition to this problem may be present, and depressive diseases run in families
- Predisposing factors: Childhood traumas, car accidents, brain injuries, abuse and domestic violence, poor parenting, growing up in an alcoholic home, chemotherapy
- Immediate factors: violent attack, illness, sudden loss or grief, loss of a relationship, any severe shock to the system

(Anderson, 1999, Berman & Jobes, 1994, Lester, 1998)

Internal And External Factors

What Happens If We Don't Treat Depression?

- Significant risk of increased alcohol and drug use
- Significant relationship problems
- Lost work days, lost productivity
- High risk for suicidal thoughts, attempts, and possibly death

(Surgeon General's Call To Action, 1999)

- Depression is a medical illness that will likely affect the person later in life, even after the initial episode improves
- Youth who experience a major depressive episode have a 70% chance of having a second major depressive episode within five years
- Many of the same problems that occurred with the first episode are likely to return, and may worsen

(Oregon SHDP)

Suicide Myths – What Is True?

1. **Talking about suicide might cause a person to act**
   - False – it is helpful to show the person you take them seriously and you care. Most feel relieved at the chance to talk
2. **A person who threatens suicide won't really follow through**
   - False – 80% of suicide completers talk about it before they actually follow through
3. **Only "crazy" people kill themselves**
   - False - Crazy is a cruel and meaningless word. Few who kill themselves have lost touch with reality – they feel hopeless and in terrible pain

(AFSP website, 2003)

4. **No one I know would do that**
    - False - suicide is an equal opportunity killer – rich, poor, successful, unsuccessful, beautiful, ugly, young, old, popular and unpopular people all complete suicide
5. **They're just trying to get attention**
    - False – They are trying to get help. We should recognize that need and respond to it
6. **Suicide is a city problem, not in the country or a small town**
    - False – rural areas have higher suicide rates than urban areas

- **Suicide myths, continued:**

7. **Once a person decides to die nothing can stop them - They really want to die**
   - NO - most people want to be stopped – if we don't try to stop them they will certainly die - people want to end their pain, not their lives, but they no longer have hope that anyone will listen, that they can be helped

(AFSP website, 2003)

What Should We Be Looking For?

1. Depressed or irritable mood—look for:

- Frequent crying spells
- Seldom seems happy
- Never happy in relationship (partner can't do anything right)
- "Dead" or monotone voice (or always angry)
- Directly and indirectly says "I hate my life"
- Easily irritated

- Teens may wear somber clothes
- Rebellious behavior (teens)
- Listens to music or has themes in writing with depressive or violent undertones
- Hangs around friends who appear depressed or irritable

2. Marked decrease in interest or pleasure in activities—look for:

- Withdraws or spends much time alone
- Gives up favorite activities
- Seems to have no motivation
- Frequently says "I'm bored"
- Declining hygiene
- Changes to a more troubled peer group

3. Psychomotor agitation or slowing— look for:

- Agitated, always moving around
- Moping or difficulty "getting going"

4. Significant change in appetite or weight—look for:

- Becomes a picky eater
- Snacks frequently and eats when stressed
- Becomes Quite thin or overweight

5. Significant changes in sleeping habits— look for:

- Takes more than an hour to fall asleep
- Multiple awakenings
- Wakes in early morning hours and can't return to sleep
- Sleeps more than normal

(Oregon SHDP)

6. Fatigue or loss of energy—look for:

- Too tired to do housework, to play or work
- Comes home from work or schoolexhausted
- Too tired to cope with conflict

7. Feelings of worthlessness or inappropriate guilt—look for:

- Describes self as "bad" or "stupid"
- Has no hope or goals for the future
- Always trying to please others
- Blames self for causing divorce or a death, when not to blame

8. Decreased concentration or indecisiveness —look for:

- Often responds "I don't know"
- Takes much longer to get work done
- Poor productivity at work, or increased sick days
- Headaches, stomachaches
- Poor eye contact

(Oregon SHDP)

How Do I Know If Someone Is Suicidal?

- Now we understand the connection between depression and suicide
- We have reviewed what a depressed person looks like
- Not all depressed people are suicidal – how can we tell?
- Suicides don't happen without warning - verbal and behavioral clues are present, but we may not notice them

Verbal Expressions

- Direct statements – Tone of Voice
  - "I wish I were dead"
  - "I am going to kill myself"
  - "I'm going to end it all"
  - "I don't want to live anymore"

- Indirect statements – How do we respond?
  - "No one cares if I live or die"
  - "Life is just too hard – it isn't worth it"
  - "You'd be better off without me"
  - "I just can't try anymore"

Some Behavioral Warning Signs

- Previous suicide attempts
- Serious expressions of hopelessness
- More than 6 criteria from the list of symptoms
- Increased substance abuse
- Unmotivated, irresponsible, uncaring
- Sudden happiness after a long period of depression
- Cleaning up "loose ends"
  - Giving away prized possessions
  - Making a will
  - Quitting a job

What On Earth Can I Do?

- Anyone can learn to ask the right questions to help a depressed and suicidal person
- Depression is an illness, like heart disease, and **suicidal thoughts are a crisis in that illness, like a heart attack**
- You would not leave a heart attack victim lying on the sidewalk – many have been trained in CPR
- We must learn to help people who are dying more slowly of depression

What Stops Us?

- Most of us still believe suicide and depression are "none of our business"
- Most are fearful of getting a yes answer
- What if we knew how to respond to "yes"?
- What if we could recognize depression symptoms like we recognize symptoms of a heart attack?
- What if we were no longer afraid to ask for help for ourselves, our parents, our children?
- What if we no longer had to feel ashamed of our feelings of despair and hopelessness, but recognized them as symptoms of a brain disorder?

Reduce Stigma

- Stigma about having mental health problems keeps people from seeking help or even acknowledging their problem
- Reducing the fear and shame we carry about having such "shameful" problems is critical
- People must learn that depression is truly a disorder that can be treated – not something to be ashamed of, not a weakness
- Learning about suicide makes it possible for us to overcome our fears about asking the "S" question

Learning "QPR" – Or, How To Ask The "S" Question

- It is essential, if we are to reduce the number of suicide deaths in our country, that community members/gatekeepers learn "**QPR**"
- First designed by dr. Paul Quinnett as an analogue to CPR, "**QPR**" consists of
  - **Q**uestion – asking the "S" question
  - **P**ersuade– getting the person to talk, and to seek help
  - **R**efer – getting the person to professional help

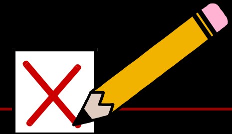
(Quinnett, 2000)

Ask Questions!

- You seem pretty down
- Do things seem hopeless to you
- Have you ever thought it would be easier to be dead?
- Have you considered suicide?
- Remember, you cannot make someone suicidal by talking about it. If they are already thinking of it they will probably be relieved that the secret is out
- If you get a yes answer, don't panic. Ask a few more questions

How Much Risk Is There?

- Assess lethality



  - You are not a doctor, but you need to know how imminent the danger is
  - Has he or she made any previous suicide attempts?
  - Does he or she have a plan?
  - How specific is the plan?
  - Do they have access to means?

Risk Assessment Mnemonic

- Do you feel you are up the creek without a paddle?
- **P**revious attempts
- **A**lcohol, drug use, agitation
- **D**epression
- **D**eveloped a plan
- **L**oss of hope, lack of support
- **E**xpressed suicidal thoughts, exhausted

Do . . .

- Use warning signs to get help early
- Talk openly- reassure them that they can be helped - try to instill **hope**
- Encourage expression of feelings
- Listen without passing judgment
- Make empathic statements
- Stay calm, relaxed, rational

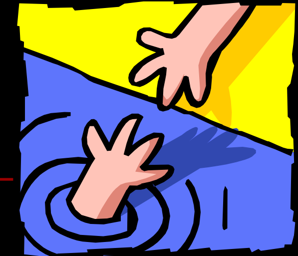
Don't…

- Make moral judgments
- Argue lecture, or encourage guilt
- Promise total confidentiality/offer reassurances that may not be true
- Offer empty reassurances – "you'll get over this"
- Minimize the problem -"All you need is a good night's sleep"
- Dare or use reverse psychology - "You won't really do it" - - "Go ahead and kill yourself"
- Leave the person alone

Never Go It Alone!

- Collaborate with others
  - The person him/herself
  - Family and friends
  - School personnel or co-workers
  - Emergency room
  - Police/sheriff
  - Family doctor
  - Crisis hotline
  - Community agencies

Getting Help



- Refer for professional help
  - When people exhibit 5 or more symptoms of depression
  - When risk is present (e.g. Specific plan, available means)
  - Learn your community resources – know how to get help

Local Professional Resources

- Your Hospital Emergency Room
- Your Local Mental Health Agencies
- Your Local Mental Health Board
- School Guidance Counselors
- Local Crisis Hotlines
- National Crisis Hotlines
- Your family physician
- School nurses
- 911
- Local Police/Sheriff
- Local Clergy

Survivors Of Suicide

- Sources of support for families of suicide completers are almost non-existent, unless a survivors of suicide group is available
- If you know people who have experienced this tragedy talk with them about it
- Explain what you know about depression - help them understand they are not at fault, that their loved one was ill
- Help them understand the unendurable psychache their loved one experienced –it may help them resolve some of their anger

Final Suggestions

- You may know many people with depression
- Are they comfortable telling you about this vulnerable place in their life?
- Openness and discussion about depression and suicidal thinking can free people to talk
- Help spread the word in your church, PTA group, sports team, circle of friends
- Help people emerge from the stigma our culture has placed on this and other mental health problems
- Become aware of your own vulnerability to depression

(Anderson, 1999)

Permanent Solution- Temporary Problem

- Remember a depressed person is physically ill, and cannot think clearly about the morality of suicide, cannot think logically about their value to friends and family
- You would try CPR if you saw a heart attack victim
- Don't be afraid to "interfere" when someone is dying more slowly of depression
- Depression is a treatable disorder
- Suicide is a preventable death

"Never forget that a handful of committed people can change the world. Indeed, it is the only thing that ever has."

Margaret Mead

Websites For Additional Information

- Ohio department of mental health

  www.mh.state.oh.us
- NAMI

  www.nami.org
- Suicide Prevention Resource Center

  www.sprc.org

American association of suicidology

www.suicidology.org

- Suicide awareness/voice of education

  www.save.org
- American foundation for suicide prevention

  www.afsp.org
- Suicide prevention advocacy network

  www.spanusa.org
- QPR institute

  www.qprtinstitute.org

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