SAVING LIVES:

Understanding Depression And Suicide In Our Communities – A Training for Clergy and Church Leaders

Sponsored By The Ohio Suicide Prevention Foundation

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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

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

Today's Training Objectives

- Increase knowledge about the impact of suicide within church and 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

What Is Mental Illness?

- None of us are surprised that there are many ways for an organ of the body to malfunction
- Stomachs can be affected by ulcers or excessive acid; lungs can be damaged by environmental factors such as smoking, or by asthma; the digestive tract is vulnerable to many possible illnesses
- We seem unaware that the brain is also vulnerable to a variety of illnesses and disorders
- We confuse brain with mind

What Is Mental Illness?

- We understand that something like Parkinson's damages the brain and creates behavioral changes
- Even diabetes is recognized as creating emotional changes as blood sugar rises and falls
- Stigma about illnesses like depression, schizophrenia and Bi-Polar disorder seems to keep us from seeing them as brain disorders that create changes in mood, behavior and thinking

What Is Mental Illness?

- We called it mental illness because we wanted to stop saying things like "lunacy", "madness", "bats in her belfry", "nuttier than a fruitcake", "rowing with one oar in the water", "insane", "ga ga", "wacko", "fruit loop", "sicko", "crazy"
- Is it any wonder people avoid acknowledging mental illness?
- Of all the diseases we have public awareness of, mental illness is the most misunderstood
- Any 5 year-old knows the symptoms of the common cold, but few people know the symptoms of the most common mental illnesses such as depression and anxiety

Mental Illness and Stigma

- Historical beliefs about mental illness color the way we approach it even now, and offer us a way to understand why the stigma against mental illness is so powerful
- For most of our history, depression and other mental disorders were viewed as demon possession
- Afflicted people were "outside the gates", unclean, causing people to fear of the mentally ill
- Lack of understanding of illness in general led people to fear contamination, either real or ritual

The Feel of Depression

- "What I had begun to discover is that…the grey drizzle of horror induced by depression takes on the quality of physical pain. But it is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain…comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion."

William Styron, 1990

The Feel of Depression

- "I am 6 feet tall. The way I have felt these past few months, it is as though I am in a very small room, and the room is filled with water, up to about 5' 10", and my feet are glued to the floor, and its all I can do to breathe."

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)

I s Suicide Really a Problem?

- **89** people complete suicide every day
- **32,637** people in 2005 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-2003

- Rates per 100,000 population
  - National average - 11.1 per 100,000*
  - White males - 18
  - Hispanic males - 10.3
  - African-American males - 9.1 **
  - Asians - 5.2
  - Caucasian females - 4.8
  - African American females - 1.5
  - Males over 85 - 67.6
- Annual Attempts – 811,000 (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)

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
- Why the differences?

How Are the Religious Affected by Depression?

- Depends on religious beliefs
- Experiencing depression is perhaps more stigmatized among believers than even in the general public
- Depression is often viewed as a failure of faith rather than as an illness
- The concept of depression as a spiritual failure may lead people to avoid acknowledging depressed thoughts and feelings

How Are the Religious Affected by Depression?

- Lack of knowledge about the symptoms of this illness may mean that people are unaware they are suffering a physical illness
- The negative thinking endemic to depression means depressed people blame themselves, their lack of faith, or view themselves as unacceptable to God
- Religious people may avoid seeking medical/ psychotherapeutic help for a medical issue if they view it as a spiritual shame

(Kennedy, 2000; WHO article, 2002)

- See the book Why Do Christians Shoot Their Wounded by Dwight Carlson, MD

To Be Or Not To Be?

- From earliest times until this moment, society has never been indifferent to suicide
- Early on, suicide has been viewed as an act of heroism, but for the last 1500 years, at least in western culture, it has been subject to disgust, ferocious punishment, and fear of damnation
- Historical and religious beliefs about suicide color the way we approach it even now, and offer us a way to understand why the stigma against mental illness and suicide are so powerful

Ancient Civilizations

- The Greeks viewed suicide as an acceptable death, as long as it was for the purpose of redeeming honor, grief, or patriotic principle
- The Romans took it one step further – allowing suicide when one became tired of living – the Senate in Marseilles kept on hand a flask of Hemlock for those desiring to end their lives (Alvarez. 1971)
- The Hebrews had no serious objection to suicide, mentioning it in terms of redeeming honor like the Greeks (Lieberman, 2002)

Early Christianity

- Throughout the New Testament the apostles invite the faithful to despise earthly life as an exile from God
- Many of the faithful were predisposed to voluntary death
- During religious persecutions by the Romans many were martyred, and were applauded for their acts
- However, once the empire embraced Christianity, the role of the martyr was essentially over
- Furthermore, Christian death must testify to faith, not be sought out of despair
- It took several centuries and great deal of theological and political skill to create a cultural climate that rejected suicide

Man's Chief End…

- Refusing God's gift of life offended both church hierarchy, those in charge of God's gifts, and civil rulers, who organize society
- The early church declared we exist to glorify God and to make ourselves useful
- Anyone who rejects their role deserves punishment
- This was the uncontested view of the suicide throughout the Middle Ages

Divine Rule

- Theologians in the early centuries of the church usually condemned suicide in principle but admitted a few exceptions
  - Killing oneself to carry out an order of civil authorities
  - To escape shame
  - To avoid an overly cruel fate
- In practice, it was unclear – many sins received strict discipline but no sanctions were present in canon law against suicides
- The Council of Carthage condemned voluntary death in 348

Divine Rule

- By 381, prayers could no longer be said for suicides, implying damnation
- Augustine's 5th Century "City Of God" proclaimed ideas about suicide that became church law – no man my inflict death upon himself at will, as it leads to eternal damnation
- Augustine condemned suicides as cowards incapable of withstanding trials, vain souls who consider only what others think of them
- In church doctrine following Augustine, killing oneself adds a second crime to the first - as with Judas

Roman Rule

- In the fifth and sixth centuries, an acute shortage of manpower meant all human lives were needed to service the economy and defend the empire
- Harsher civil legislation resulted
- Possessions of those who completed suicide were confiscated by the state
- So, in combination, church and state began a repressive assault on suicide
- Social, economic and political conditions put pressure on morality, criminalizing suicide as an offense against God and society

Diabolic Despair

- Once the framework for despising suicide was in place, moralists and poets assisted in getting the word out to the public
- Dante reserved a special place for suicides among the violent in the 7th circle of hell
- Despair in the 12th century was not a psychological state but a sin prompted by the devil, who persuades the sinner that damnation is certain
- The church made use of circulating tales, sermons and mystery plays to explain the moral position on suicide
- The moral was always that one must not despair since miracles are always possible

Treatment of Suicide Completers

- In England the body was buried under the road at a busy crossroad, and pinned to the ground by driving a wooden stake through the chest
- Thus there was less chance the spirit would emerge to haunt the living (a holdover from early beliefs)
- Suicide, a malefic death, was an illustration of the work of the powers of evil, identified as the devil
- The execution of the corpse was a rite of exorcism and an example to others
- Confiscation of the estate appears in France as early as 1205

The Role of Insanity

- Because punishments were so harsh, the least sign of strange behavior could be interpreted as proof of madness
- The definition of madness was broadly perceived and pity for the victim's family enlarged its definition farther
- If possible, deaths by suicide were determined to be the result of insanity so that the family would not suffer loss of property
- In England, the "coroner" did not receive pay, and thus was frequently bribed by family members to call a suicide an accident

Where Did The Suicidal Go For Treatment?

- In England and other countries, "madmen" were housed at hospitals like Bethlehem in London, from which we get the word Bedlam
- Here is where the phrase Insane Asylum became better known – asylum was a positive word before it became attached to insanity
- Just like today, many people with mental illness became homeless, and wandered the cities and countryside, easy victims, avoided by most

Biblical Perspectives On Suicide

- Nothing in Biblical scripture suggests that suicides will experience eternal punishment
- Of the seven or so suicides reported in Scripture, most familiar are Saul, Samson, and Judas
  - Saul died to avoid dishonor and suffering at the hands of the Philistines- He is rewarded by the Israelites with a war hero's burial, there being no apparent disapproval of his suicide (1 Sam. 31:1-6)
  - While there is no hero's burial for Judas Iscariot (Matt. 27:5-7), Scripture is once more silent on the morality of this suicide of remorse
- The suicide of Samson has posed a greater problem for theologians
- Both Saint Augustine and Saint Thomas Aquinas wrestled with the case and concluded that Samson's suicide was justified as an act of obedience to a direct command of God

The Rise of Belief in Suicide As Sin

- Thomas Aquinas believed that suicide, by excluding a final repentance, was a mortal sin
- Dante is likely to have influenced Christian thought at least as much as Saint Thomas, placing those who committed suicide in the seventh circle of the inferno
- Luther and Calvin, despite their abhorrence of suicide do not suggest that it is an unpardonable sin
- The pedigree of the view that suicide is unforgivable seems to lie in the medieval church

(Kennedy, 2000)

Islam and Suicide

- Clear injunctions are present in the Koran against suicide
- Current debate on so-called "suicide bombers" is raging among Muslim theologians
- Many regard suicide bombers as completely misunderstanding their faith and the appropriateness of "dying for the faith"

(Muttaquan Online, 2004)

Impact Of Religious Beliefs On Suicidal Thinking

- Those with religious affiliation, compared to those without:
  - Usually find suicide less acceptable
  - Are less likely to have suicidal ideation
  - Are less likely to have attempted suicide
  - Youth in particular are protected by religious faith
  - This holds true regardless of the faith

(Smith, Range & Ulner., 1992)

Suicide Among The Religious

- Among the most common faith groups in the U.S.:
  - Protestants have the highest suicide rate
  - Roman Catholics are next
  - Jews have the lowest rate
- Oddly, followers of religions that strongly prohibit suicide, like Christianity and Islam, have a higher suicide rate than those religions which have no strong prohibition (e.g. Buddhism and Hinduism

(Jacobs, 1999)

Impact Of Depression On Religious Beliefs

- Most find comfort associated with their faith
- But depression is associated with feelings of alienation from God
- Suicidality can be associated with religious fear and guilt, particularly with belief in having committed an unforgivable sin for simply thinking of suicide
- This religious strain is associated with greater depression and suicidality, regardless of religiosity levels or the degree of comfort found in religion

(Sanderson, 2000)

Factors That May Conflict With Church Attendance

- Persons who are depressed are less likely to leave their homes, want to be in groups, or to enjoy attending church, synagogue, mosque, temple, circle, etc. Also, those with social anxiety tend to avoid groups
- Homosexuals have a higher suicide rate as a group and are unlikely to attend church because of the degree of rejection they perceive they will find there
- Attendance at religious services potentially gives individuals access to a support network - those without a support network are more likely to commit suicide

(Robinson, 1999)

Apocalypse Not Now?

- In some cases, religious belief can lead to suicide
- Apocalyptic suicide among cult followers
  - Members leave the world to go to a better place
    - Marshall Applewaite-Heaven's Gate members–1997
  - Members believe they cannot live in end time or evil world, usually led by their messianic leader
    - Jim Jones and 900 members of Peoples Temple, Guyana, 1978
  - Disappointment when the "end time" does not occur
    - Order of the Solar Temple, 1994
- Islamic "murder/suicide bombers" who believe Allah ordains their act as a defensive act of war

(Dein & Littlewood, 2000;Muttaquan Online, 2004)

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

(Surgeon General's call to Action, 1999)

- The biggest risk factor for suicide completion?

Having a Depressive Illness

- People 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 (Self, World, Future)
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 (5HPA axis)**
- 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 – hormones activated by our Autonomic Nervous System to protect us in times of danger
- Chronic stress causes a change in the functioning of the ANS, so that high levels of activation occur easily
- Constant activation of the ANS causes changes in muscle tension and imbalances in blood flow patterns leading to certain illnesses such as asthma, IBS and depression

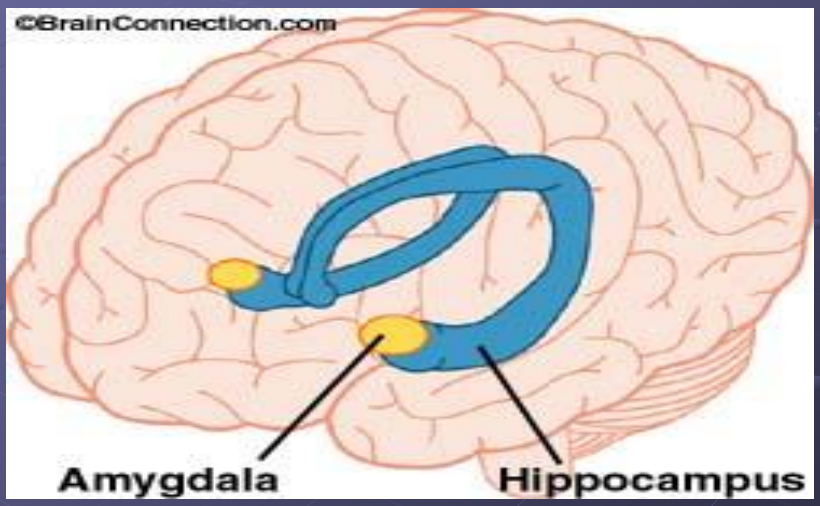
(Goleman, 1997, Braun, 1999)

Faulty Wiring?

- Without a way to return to 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

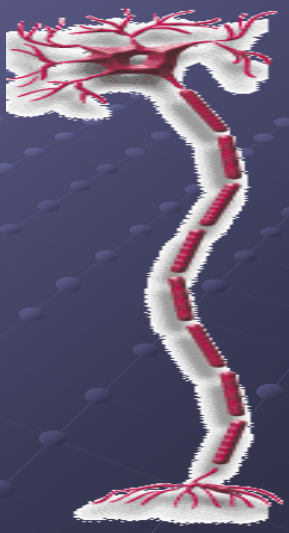
(Goleman, 1997; Braun, 1999)

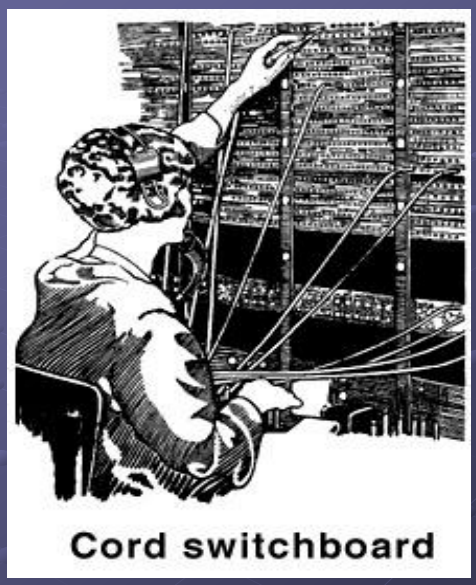
Where It Hits Us



One of Many Neurons

- Neurons make up the brain and cause 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 connections are made, more and more symptoms of depression appear





- As damage occurs, thinking, feeling, and body regulation 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 connections
- More connections mean more information flow, more flexibility, increased functioning
- 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)

Why Don't We Seek Treatment?

- We don't know we are experiencing a brain disorder – we don't recognize the symptoms
- When we talk to doctors, we are vague about symptoms
- Until recently, Doctors were as unlikely as the rest of the population to attend to depression symptoms
- We believe the things we are thinking and feeling are our fault, our failure, our weakness, not an illness
- We fear being stigmatized at work, at church, at school

No Happy Pills For Me

- The stigma around depression leads to refusal of treatment
- Taking medication is viewed as a failure by the same people who cheerfully take their blood pressure or cholesterol meds
- Medication is seen as altering personality, taking something away, rather than as repairing damage done to the brain by stress hormones

Therapy? Are You Kidding? I Don't Need All That Woo-Woo Stuff!

- How can we seek treatment for something we believe is a personal failure?
- Acknowledging the need for help is not popular in our culture (Strong Silent type, Cowboy)
- People who seek therapy may be viewed as weak
- Therapists are all crazy anyway
- They'll just blame it on my mother or some other stupid thing

How Does Psychotherapy Help?

- Medications may 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 seem to 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)

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)

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

- Common statements
  - I shouldn't be here
  - I should run away
  - I wish I could disappear forever
  - If a person did this or that, would he/she die
  - I want to see what it feels like to die
  - Maybe if I died, people would love me more
  - I wish I were dead
  - I'm going to kill myself

Some Behavioral Warning Signs

- Common signs
  - Previous suicidal thoughts or attempts
  - Expressing feelings of hopelessness or guilt
  - (Increased) substance abuse
  - Becoming less responsible and motivated
  - Talking or joking about suicide
  - Giving away possessions
  - Having several accidents resulting in injury; "close calls" or "brushes with death"

Further Behaviors Often Seen in Kids

- Preoccupation with death/violence; TV, movies, drawings, books, at play, music
- Risky behavior; jumping from high places, running into traffic, self-cutting
- School problems – a big drop in grades, falling asleep in class, emotional outbursts or other behavior unusual for this student
- Wants to join a person in heaven
- Themes of death in artwork, poetry, etc

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"?
  - We could recognize depression symptoms like we recognize symptoms of a heart attack?
  - We were no longer afraid to ask for help for ourselves, our parents, our children?
  - We no longer felt 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 a treatable disorder – 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 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?

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

- But when someone is suicidal, a true friend learns how to listen

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

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

Mourning Vs. Depression

- Some people experience both after loss of a loved one
- Mourning often creates problems in functioning for up to 6 months – can be "off and on"
- When duration of deep mourning lasts longer than 6 months, or there is guilt unconnected to the loved one's death, and there are other symptoms, depression should be assessed
- Treating depression does not 'mask" or eliminate grief, but helps with the painful symptoms of depression
- Separating the two can help people heal

(Empfield, 2003)

Bereavement After A Suicide Loss

- Compared with homicide, accidental death or natural death, suicide death is the most difficult for family members to resolve
- Family members experience:
  - Greater pain
  - More difficulty finding meaning in the death
  - More difficulty accepting the death
  - Less support and understanding from others
  - More need for mental health care

(Smith, Range & Ulner, 1991)

- Suicide death is so stigmatized that many families never talk about it, never receive support from others, creating a "conspiracy of silence" that keeps people from closure
- This silence causes major damage to sibling relationships, marriages, and future happiness
- Drug and alcohol addiction may increase
- Anger and shame lead family members to be more vulnerable to suicide themselves

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 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 For Helping Your Congregation

- How many members of your congregation experience depression?
- Are they comfortable telling you about this vulnerable place in their life?
- Openness and discussion by church leaders about depression and suicidal thinking can free people to talk about their own situations
- Help your congregation to understand that depression is not a "loss of faith" or a spiritual failure
- Help people emerge from the stigma our culture has placed on this and other mental health problems
- Consider setting up depression/anxiety awareness and support groups
- Become aware of your own vulnerability to depression (Anderson, 1999)

Websites For Additional Information

- Ohio department of mental health
  www.mh.state.oh.us
- NAMI
  www.nami.org
- National institute of mental health
  www.nih.nimh.gov

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
- Suicide Prevention Resource Center www.sprc.org

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

The Ohio Suicide Prevention Foundation

The Ohio State University, Center on Education and Training for Employment
1900 Kenny Road, Room 2072
Columbus, OH 43210

614-292-8585

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