SAVING LIVES:
Understanding Depression And Suicide In Our Communities

The Greene County Suicide Prevention Coalition

Presented and Developed By Ellen Anderson, Ph.D., PCC, 2003-2008

"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

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
- Up to 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. 1996)

What Is Mental Illness?

- Prior to our understanding of illness caused by bacteria, most people thought of any illness as a spiritual failure or demon possession
- Contamination meant spiritual contamination
- People were frightened to be near someone with odd behavior for fear of being contaminated

What Is Mental Illness?

- What do we say about someone who is odd?
  - Looney, batty, nuts, crazy, wacko, lunatic, insane, fruitcake, psycho, not all there, bats in the belfry, gonzo, bonkers, wackadoo, whack job
- Why would anyone admit to having a mental illness?
- So much stigma makes it very difficult for people to seek help or even acknowledge a problem

What Is Mental Illness?

- We know that illnesses like epilepsy, Parkinson's and Alzheimer's are physical illness in the brain
- Somehow, clinical depression, anxiety, Bi-Polar Disorder and Schizophrenia are not considered illnesses to be treated
- We confuse brain with mind

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."

Is Suicide Really a Problem?

- **83** people complete suicide every day
- **32,466** 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-2005

- Rates per 100,000 population
  - National average - 11 per 100,000*
  - White males - 19.9
  - African-American males - 9.1 **
  - Hispanic males - 10.7
  - Asians - 5.2
  - Caucasian females - 4.8
  - African American & Hispanic females - 1.5
  - Males over 85 - 67.6
- Annual Attempts – 810,000 (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
- 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

(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. Usually, suicidal thoughts

(DSMIVR, 2002)

- 20 years of brain research teaches that these symptoms are the **behavioral** result of
  - **Changes in the physical structure of the brain**
  - **Damage to brain cells in the hippocampus, amygdala and 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?

- Damage to 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
- Chronic stress causes changes in the functioning of the ANS, so that high levels of activation occur with very little stimulus
- Creates changes in muscle tension, imbalances in blood flow patterns leading to certain illnesses such as asthma, IBS and depression

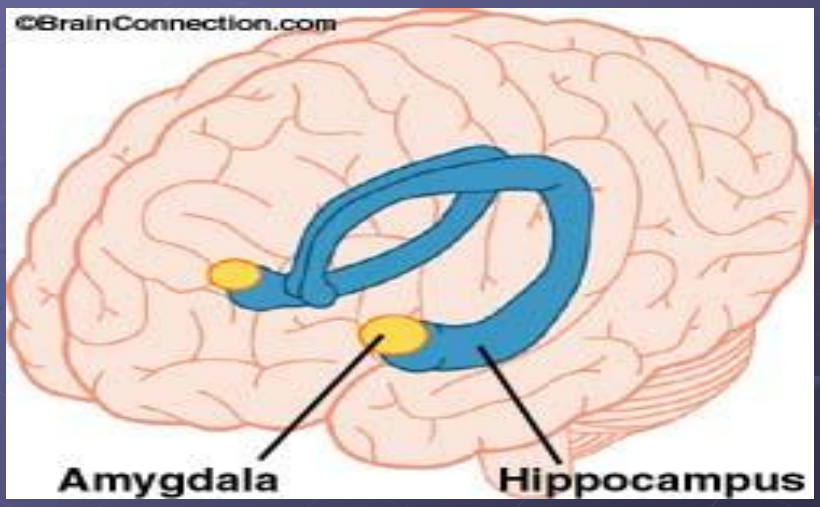
(Braun, 1999)

Faulty Wiring?

- Without out a return to a baseline of rest, hormones accumulate, doing damage to brain cells
- 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
- Stress alone is not the problem, but how we interpret the event, thought or feeling

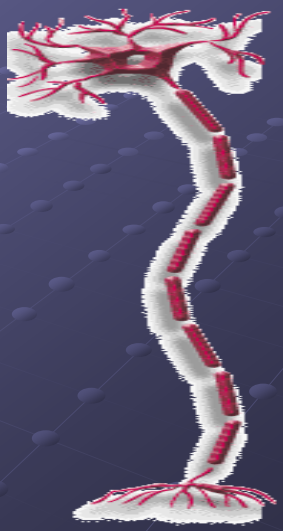
(Goleman, 1997; Braun, 1999)

Where It Hits Us



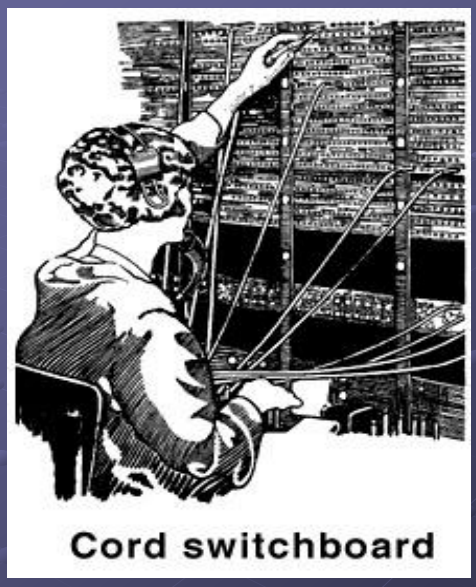
One of Many Neurons

- 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
- The more connections, the more information flow, the more flexibility 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 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 triggers: 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 (up to $40 billion a year)
- 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 a rural problem**
   - 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)

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 actively 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'm going to run away
  - I wish I could disappear forever
  - If a person did this or that., would he/she die
  - Maybe if I died, people would love me more
  - I want to see what it feels like to die
  - 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" and are fearful of getting a yes answer
- What if :
  - we could 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 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?

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

The Ohio Suicide Prevention Foundation

The Ohio State University, Center on Education and Training for Employment

1900 Kenny Road, Room 2072

Columbus, OH 43210

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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