survival ...AND BEYOND

A guide to create awareness and help understand the dynamics of depression, suicide, and the power of the family as a resource.

FOREWORD

Survival and Beyond and its accompanying guide is designed to help educators and students understand the dynamics of challenging issues in relationships and families.This program presents the true story of one family's history with depression and suicide. These issues can affect anyone at any age. Students and their families are faced with the loss of siblings, parents, children, friends and peers through suicide.

In schools, teachers and students are often in a position of having to cope with the grieving process without having the facts or the ability to fully understand what is happening.

This program is a valuable resource for seasoned teachers and community instructors who wish to provide relevant and useful instruction about depression and suicide.

Carole MacFarlane
Career Programs Coordinator,
Vancouver School Board

Produced by:

Additional support provided by:

Scotiabank

Survival and Beyond

Video produced by:
Erna Wine Maurer

DVD adaptation and design:
Adam Abrams

Facilitators' Guide

Development Team

Erna Wine Maurer
Linda Rosenfeld
Maria Pettersen
Adam Abrams

Contributing Writers

Patrick Arbore, Ed.D
Jane Thomas, Ed.D

INTRODUCTION

It is estimated that one in ten North Americans suffers from depression or will experience a depressive episode at some point in their lives. Despite the widespread incidence of depression, there is still considerable misunderstanding about its causes and treatments. The social stigma associated with this condition often prevents people from seeking appropriate support.

Suicide is the 11th most common cause of death in the U.S. and the 6th in Canada–killing over 30,000 people and 3,000 people respectively.

Survival and Beyond presents a sensitive and thought-provoking account of the experience of depression and suicidal behaviour in one family. Three generations of family members speak about the changes in family functioning and relationships through the course of major depressive episodes and repeated suicide attempts of one family member over a period of many years.

GOALS AND OBJECTIVES

Goals

The purpose of this video and its accompanying guide is to promote awareness of the issues of depression and suicidal behaviour within the context of intergenerational family dynamics, and to provide educators and health care professionals with suggestions for its use in a variety of contexts.

Objectives

- To understand depression and its relationship to suicidal behaviour from an intergenerational perspective
- To facilitate discussion about issues related to depression and suicidality as they occur in the family context
- To explore the role of family members in the prevention and intervention of suicidal behaviour

DEPRESSION AND SUICIDE INFORMATION

Who Becomes Depressed?

Depression can occur at any stage of life, and knows no socio-economic, cultural or ethnic boundaries. Although key defining features of depression are the same, there may be significant differences in the presentation and recognition of depression in various groups. Among adolescents, who may have difficulty in identifying and communicating their internal state, depression may be manifest in acting-out behaviour, irritability or defiance, and may be perceived as teenage moodiness. In the elderly, depression affects approximately 10% of the population, but it may present more subtly than in other age groups. Indeed, elderly patients typically do not report a depressed mood to their physicians; rather, they describe symptoms of general physical ill health. The focus on physical ailments then contributes to the possibility of depression being ignored. In ethnic minorities it is often difficult to detect due to variations in culturally acceptable expressions of emotional distress.

HOW TO USE THIS RESOURCE

This resource can be used effectively in a wide range of contexts. Instructors of courses such as Family Psychology, Sociology, or Career Preparation in Human Services can assist students in examining patterns of family communication and interaction, the impact of mental illness on family functioning, and appropriate responses to suicidal behaviour. This resource can also be used by educators in professional training programs such as nursing, social work, clinical psychology, and gerontology.

Survival and Beyond is 30 minutes in length and is composed of four segments. The video may be viewed in its entirety. An alternative suggestion is to view the first segment independently, focusing on the person who is depressed and suicidal. The rest of the video addresses the family dynamics and can be shown later.

There are suggested topics for discussion under four headings:

- *Depression and Suicide*
- *Understanding Suicidal Behaviour*
- *Multigenerational Effects on the Family*
- *Awareness and Support*
- *Clinical Issues for Discussion*

The group leader may choose from a variety of thought-provoking questions and specific information, depending upon the age, level of knowledge/skill of the participants, composition of the group and the desired outcome.

DEFINITIONS

Depression
Can be a mood disorder brought on be chemical changes (clinical depression) or a reaction to loss or change in ones life (reactive depression). Symptoms are helplessness, low self esteem, sadness, despair, inability to function as previously, loss of appetite, isolation, insomnia, loss of pleasure or interest. Depression affects the way one thinks, feels, (physically and emotionally) and acts.

See the following in the *Additional Resources* section:

Elderly Suicide Fact Sheet, page E1
Older Adults: Depression and Suicide Facts, page E2
Suicide in the Older Adult, page E7

Panic Attacks:
Recurrent, unpredictable episodes of sudden intense apprehension or fear. The symptoms may include palpitations, chest pain, dizziness, sweating, fainting, choking sensation or fear of dying.

Panic Disorder:

To meet the criteria of "disorder" it needs to be three panic attacks in a three week period not precipitated by exposure by a fearful situation.

At risk

Potentially suicidal.

Suicide Ideation:

Thinking about suicide.

Suicide Gesture

There may be little intent to die, but the behaviour indicated distress.

Suicide Threat

Communication to others of the intent to commit suicide.

Suicidal Act:

Self-inflicted injury to varying degrees.

Suicide Attempt

Committing a suicidal act without it resulting in death.

Completed Suicide

Any lethal, intentional, self-inflicted act that results in death.

Para-suicides

Self injury - may or may not be suicidal behaviour (e.g. self-mutilation).

UNDERSTANDING DEPRESSION AND SUICIDE

Can you explain to someone the difference between "down days" or "feeling blue" and depression?

Depression can surface at any time during one's lifespan. Biochemical changes in the brain can be triggered by many factors, just as depression in reaction to situational causes can. Loss or multiple losses can be so severe that one's usual coping skills become ineffective. This is usually linked to depression. It is important to remember that depression is different from sadness or unhappiness, because low self-esteem or unworthiness is present. Joe Sr. experienced loss of a marriage but also loss of the dream of a happy marriage. He also experienced this loss as a failure, which led to low self-esteem.
See page 5.11.

Do you think it is possible for people to never experience any "down days"? Is this something to aspire to?

If you experience "down days", you might feel guilty or feel something is wrong with you. We fight off our down days by behaving in ways that don't allow negative feelings, such as overachieving or drinking.

If someone's "mind is dominated by depression" are they able to make a clear decision regarding suicide?

When depression occurs, negative thinking predominates and individuals usually have a pessimistic view of their world. When they are in this emotional state, they cannot make a "clear decision" because they feel hopeless and cannot "see" alternatives. This is called constriction of thought. It is temporary, and changes when depression lifts. However, even in the midst of despair, there is almost always ambivalence. The life force is strong, and people who wish to escape their pain usually wish there was another option to death.

continued

TRANSCRIPT

The following transcript enables the facilitator to recall and identify specific issues for discussion and exploration.

Dr. Buckwalter Sr.

I was determined that I ... the only way out was to kill myself. I planned it all very carefully, I went to the hospital and I went into my office and locked the door. This was about 8, 9 o'clock in the morning, there were very few people in the clinic area because it was a holiday, and I sat at the desk and had a glass of water and took the uh, one hundred, hundred milligrams capsules, which was about at least 50 times the normal dose.

They found me slumped over my desk. It was 5 days later in the intensive care unit ..... I still was ... had a tube in my trachea. I hadn't really awakened.....it was just at the last moment when they were about to cut my throat and do the tracheostomy.....I woke up. That was the first suicide attempt.

This came on right after the ending of a contested, very unpleasant divorce suit and custody fight for the four children. So it was only after the battle was over, so to speak, within a month or so that I began for the first time in my life to ever feel depressed.

The way it began..... was that I lost my zest for all things that were important in my life... problem which resulted in the need for the divorce and the custody of the children was my first wife's illness, which developed over a period of uh... more than 15 years.

Even though she was a physician, she had consistently denied uh... ... denied that there was a problem that she was involved in at all.

I informed her that if she continued to refuse to try to go with me to somebody who would be competent to advise us concerning our relationship and what I consider to be her problem..... her progressing problem, then I would have no choice.

Older Adults: Depression and Suicide Facts

Source: NIMH (National Institute of Mental Health)

Major depression, one of the most common conditions associated with suicide in older adults[1], is a widely underrecognized and undertreated medical illness. In fact, several studies have found that many older adults who die by suicide have visited a primary care physician within a month of their suicide.[2] These findings point to the urgency of improving detection and treatment of depression as a means of reducing suicide risk among older persons.

Older Americans are disproportionately likely to die by suicide. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older: 59 deaths per 100,000 persons in 2000, more than five times the national U.S. rate of 10.6 per 100,000.[3]

Of the nearly 35 million Americans age 65 and older, an estimated 2 million have a depressive illness (major depressive disorder, dysthymic disorder, or bipolar disorder) and another 5 million may have "subsyndromal depression," or depressive symptoms that fall short of meeting full diagnostic criteria for a disorder.[4,5] Subsyndromal depression is especially common among older persons and is associated with an increased risk of developing major depression.[6] In any of these forms, however, depressive symptoms are not a normal part of aging. In contrast to the normal emotional experiences of sadness, grief, loss, or passing mood states, they tend to be persistent and to interfere significantly with an individual's ability to function.

Depression often co-occurs with other serious illnesses such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.[7] Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems–an attitude often shared by patients themselves.[8] These factors together contribute to the underdiagnosis and undertreatment of depressive disorders in older people. Depression can and should be treated when it co-occurs with other illnesses, for untreated depression can delay recovery from or worsen the outcome of these other illnesses. The relationship between depression and other illness processes in older adults is a focus of ongoing research. Both doctors and patients may have difficulty identifying the signs of depression. NIMH-funded researchers are currently investigating the effectiveness of a depression education intervention delivered in primary care clinics for improving recognition and treatment of depression and suicidal symptoms in elderly patients.[9]

continued

Suicide Warning Signs List

Instructions: If you or someone you know is thinking about suicide or showing a lot of these signs, be sure to get help immediately from your counselor or another adult.

Things a person might do

1. Give away prized possessions
2. Possess or get a weapon such as a knife or gun
3. Make a plan for committing suicide
4. Show sudden mood swings (be very happy after being very depressed)
5. Have attempted suicide before
6. Make a will and put personal affairs in order
7. Be self-destructive physically or in other ways
8. Show a change in eating habits (eating too much or too little)
9. Show belligerent, acting-out, or destructive behavior
10. Neglect to take care of physical appearance
11. Complain about physical problems (e.g., headaches)
12. Get in trouble with the law
13. Break up with a boyfriend or girlfriend
14. Write poems or make drawings about death
15. Drive while drinking
16. Show a drop in grades or have frequent absences from school

Things a person might say

1. Talk openly about committing suicide ("I think I'll just end it all.")
2. Ask questions about suicide (what would it be like, etc.)
3. Talk about not being around in the future
4. Talk about different ways to commit suicide
5. Say things that don't make sense or are confused
6. Say that things that used to be fun aren't fun anymore
7. Talk about revenge, "getting even" with someone
8. Say negative things about self, express self-blame and guilt

Things a person might feel

1. Depression, apathy ("don't care" attitude)
2. Irritability, restlessness, agitation, inability to relax
3. Fatigue, low energy nearly every day
4. Hostility, desire for revenge
5. Indecision
6. Lack of concentration
7. A sense of being a failure or worthless
8. Hopelessness, helplessness
9. Dissatisfaction with everything and everyone
10. A sense of being unloved, unwanted, rejected
11. Extreme stress
12. A lack of control
13. A lack of support from any source

Things that might have happened

1. Losing a relative or friend to death, divorce, or moving away
2. Having family problems such as job loss or alcohol/drug abuse
3. Losing money or prestige, having to move to a less desirable house or apartment
4. Failing in a class or being held back a grade in school
5. Having a boyfriend or girlfriend break off a relationship
6. Finding out about a medical illness
7. Experiencing parents' divorce

Assessment Goals

1 To determine if client is suicidal.

2 To determine risk level; low, medium, high.

3 To evaluate available sources of support; familial, social, community resources and present coping skills.

4. If inadequate relative to perceived risk, act to ensure the client's safety.

LATER

Continuity of care & ongoing support beyond the immediate suicidal crisis.

When	Is Coupled	With
Severe depression	⇨	Poor self-esteem
Hopelessness	⇨	Impassivity
Anhedonia	⇨	Aggressivity
Frantic anxiety	⇨	Rigidity &/or Difficulty in compromising

...and the individual is isolated

they are at extreme risk.

Asking the Question

I - OUTLINE

1. The question:

- Ask directly and openly about suicide.
- Be aware of your tone, timing, and relationship.
- Rephrase the question throughout the interview.
- There will be generally two responses to this question:

i ***"No":*** If this is the response, be sure to discuss a suicide safety plan in case the person becomes suicidal in the future, or in case they do not feel comfortable discussing their real feelings. Continue on to #6.

ii ***"Yes" or "Maybe":*** If this is the response, continue on to #2.

2. Maintaining Rapport:

- An open-ended invitation to gather more information and to validate.
- Gives permission which reduces anxiety around stigma and secrecy.

3. Current Stressors:

- Empathize by paraphrasing and by maintaining good eye contact and an attentive listening posture.
- Explore current stressors and events.
- Explore symptoms such as substance misuse, constriction of thought, feeling, or behaviour, inability to communicate, perceptions and distortions, sleeping and eating irregularities, and changes in mood and energy.

4. History:

- Determine the lethality of prior attempts and what intervention was employed; eg. Was there self rescue?
- Current intervention strategies may depend on this information; eg. If it helped to see a counsellor in the past, would they attempt to reestablish contact?

5. Urgency:

- Explore if they have the means and/or a date to kill themselves.
- Get a sense of their impulse control; eg. Are they able to tolerate these painful feelings for a while until they can get connected or counselling?

continued

Tips for Handling Suicidal Individuals

- Don’t be afraid to ask directly about suicide.
- Speak about suicide openly and freely. Don’t act shocked. Be empathic.
- Encourage the person to talk about problems + express feelings.
- Listen and allow silences while the person inwardly explores or reflects.
- Be non-judgmental about the person’s suicidality, and about the person's values and morals.
- Don’t lecture or give advice. Offer suggestions tentatively, but only when the person fails to come up with possibilities.
- Don't ask “why” questions.
- Take the position that suicide is not the answer. Offer hope that alternatives exist.
- Never agree to secrecy.
- Assess risk, needs and resources.
- Devise a safety plan.

NOTES: ★ NEVER leave a high/imminent risk person alone.

★ If you can’t work out a safety plan, seek outside emergency intervention.