Depression and Suicide:
Mental Health Tools for Providers Working With College-aged Youth

Christina Ruggiero, RP

May 11, 2023

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Disclaimer and Funding Statement

At the time of this presentation, Miriam E. Delphin-Rittmon, Ph.D. served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Christina Ruggiero, CCP, RP and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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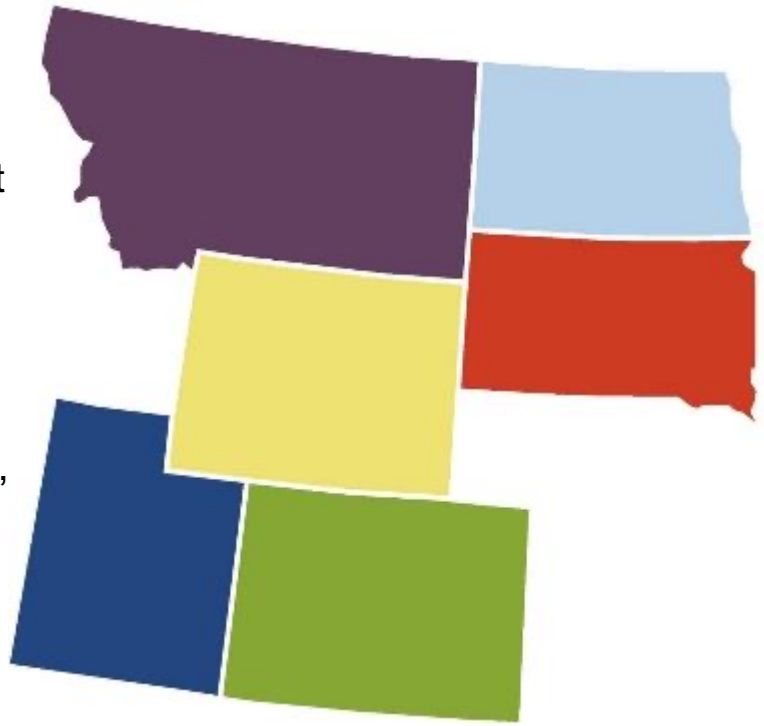
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use, and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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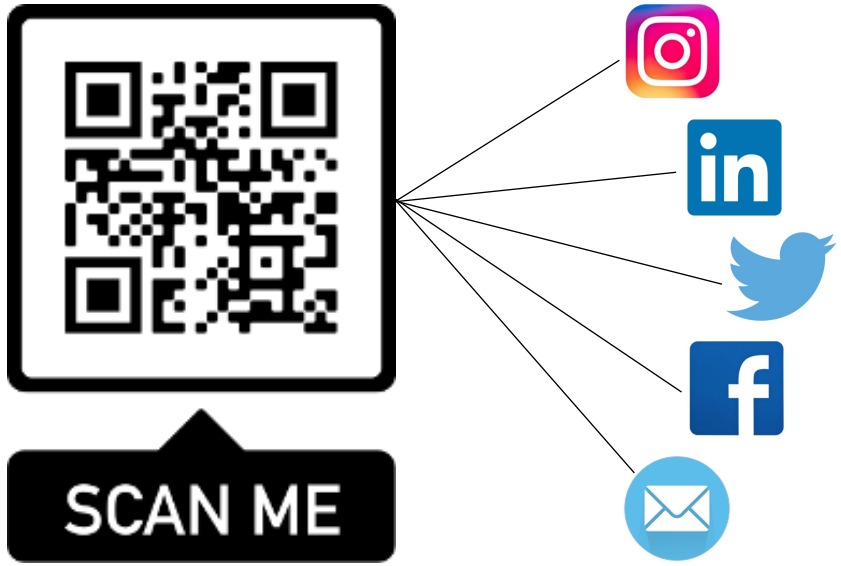

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Christina Ruggiero (she/her)

Masters of Counselling Psychology, Registered Psychotherapist

What is Depression?

Depression (Major Depressive Disorder) is the most prevalent mental health disorder. The lifetime risk for depression is 6% to 25%. According to the National Institute of Mental Health (NIMH), 9.5% or 18.8 million American adults suffer from a depressive illness in any given year.

Depression is a common and serious medical illness that negatively affects how you feel, the way you think, and how you act. Fortunately, it is also manageable with support.

Know the Signs:
The 9 Symptoms Of Depression

Loss of Energy

No Concentrating

Loss of interest /
Pleasure in hobbies and activities

Appetite/
Weight changes.

Sleep Problems

Feelings of
Worthlessness/Guilt

Thoughts of Death

Depressed mood

Feelings restless/
Else very sluggish

THE DEPRESSION PROJECT

@RealDepressionProject

Signs and Symptoms of Depression in the Office

Overgeneralizing statements

- Nothing! I haven't gotten out of bed all week, I didn't eat all week, I haven't left the house all week, I cant concentrate at all, I always feel bad, I always feel hopeless.

Lack of energy, lethargy

- Slumped over or hunched over in chair, little movement, shallow breathing, tearful/crying, numbed out/no emotions, little eye contact.

Stuck-ness

- There's nothing I can do, there's nothing I can change, what's the point, "ya but", "I cant", but if I do that then something negative will happen. If I do that it won't change anything.

Intense inner critic/shame

- I'm such a bad person, I'm so lazy, other people can do these things why can't I? I stayed in bed when I should have been working, I stayed inside when I should have been exercising, people would be better off without me, no one cares about me, I cant believe I'm acting this way.

Myths and Stigma of Depression

Myths and Stigma

- Someone's lazy, they should shrug it off and start doing stuff.
- Someone is weak, they should just get over it.
- I was depressed once…XYZ and poof!
- Choice to be antisocial, have a bad attitude.
- You look fine! How can you have depression?

- Invalidation of a persons experience.
- Myth: that if we bring up depression or suicide they will be more likely to feel depressed or follow through with suicide.

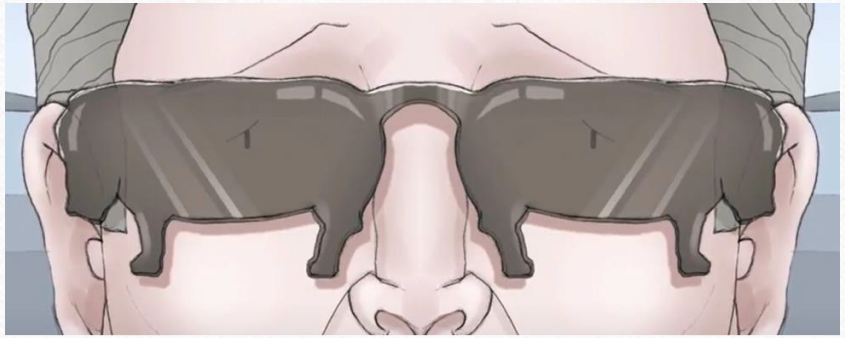
Fact

- Normal periods of low mood + depression is different.

I had a black dog… his name was depression.

https://www.youtube.com/watch?v=XiCrniLQGYc

Depression Glasses



- Two people can be in the same situation but have very different interpretations of it.
- A metaphor for depression is it is like wearing dark sunglasses in a situation, they make the world look dark and hopeless, and individuals with depression start perceiving their world as dark and hopeless also, in how they think, feel, and act.
- Recognize the sunglasses as just that. Depression is a part of an individual, it is something they have; but it does not define that individual, it is not something that they are as a whole being. There is still a client behind those sunglasses in your office aside from the depression. Helpful to see, something they have, that we can change or alter.

How is Depression linked to Suicide?

Major depression is the psychiatric diagnosis most commonly associated with suicide. The lifetime risk of suicide among patients with untreated depressive disorder is nearly 20%

About 7 out of every hundred men and 1 out of every hundred women who have been diagnosed with depression in their lifetime will go on to complete suicide.

The risk of suicide in people with major depression is about 20 times that of the general population

(Gotlib & Hammen, 2002)

Why is Depression linked to Suicide?

Over time a life with no meaning, purpose, or light in sight, can make us feel stuck.

Some individuals start thinking about an escape from this pain, and start to think of ending their lives as a way to end their suffering.

Suicide can bring hope to those that do not know how to feel better, and feel stuck. End their lives, end the depression… right?

Duty to Protect

Suicide Assessment

Purpose and Duties

- Purpose
  - To identify and evaluate warning signs that contribute to suicidality, and to determine an appropriate intervention based on the risk presented by the client.

- Duties
  - Recognize and identify suicidal warning signs and risk level of client
  - Identify protective factors that can reduce risk level of client
  - Create and implement effective prevention and/or intervention plans to reduce risk level of client

(CAMH, 2010)

Process

1. Recognize and detect risk factors

2. Recognize and detect protective factors

3. Conduct an open and detailed enquiry

4. Determine the level of risk

5. Implement counsellor response and client interventions

(CAMH, 2010)

1. Recognize and detect Risk Factors	
Demographic	- Age: after puberty, older adults (65+) - Sex: Male, LGBTQ2s+ - Status: Widowed, Divorced, Single
Individual History	- Psychiactric disorder - Previous suicide attempt - Physical or sexual abuse - Medical diagnosis - Loss & Grief - Neglect/ trauma
Genetic and Family History	- Psychiactric difficulties - Suicidal behaviours - abuse
Current Psychiactric Diagnosis	- Mood disorders: especially depression - Anxiety Disorders: especially when co-occurring with mood disorder or substance use - Schizophrenia - Personality Disorders: Especially Borderline PD
Feeling Symptoms	- Hopelessness - Anxiety/panic - Decreased self esteem - Perfectionism - Anger - Depression/numbed out - Guilt

Table 1, Risk Factors (Adapted from CAMH, 2010; CARMHA, 2007; RMFHMI, 1996)

1. Recognize and detect Risk Factors	
Behaviour Symptoms	- Impulsivity - Aggression - Agitation
Thought Symptoms	- Blank - Polarized thinking - Diminished concentration
Substance use	- Use of multiple substances (i.e. cocaine, alcohol, marijuana) - Withdrawal from addictive drugs - Extended use of sedatives, hypnotics and anxiolytics
Psychosocial	- Severe stressful life events - Periods of change (i.e. moving) - Real or perceived humiliation or loss
Living Alone	- Increased risk in unmarried men
Relationships	- Interpersonal conflict or loss (separation, divorce, death) - Social isolation - Poor perception of quality of friend and family relationships
Access to Lethal Means	- Access to firearms - large dose of medication
Physical Illness	- Chronic pain (high) - Poor tolerance of physical pain

Table 1, Risk Factors (Adapted from CAMH, 2010; CARMHA, 2007; RMFHMI, 1996)

2. Recognize and Detect Protective Factors

These possibly reduce suicidal risk levels. The mere absence of warning signs and potential risk factors can also be thought of as a protective factor (CARMHA, 2007)

Individual/ Student - Strong sense of competence - Effective interpersonal skills - Effective problem solving skills - Optimistic outlook - Recognize and manage triggers and stressors	Work/School - Sense of accomplishment - Positive peer support and colleague relationships - Supportive school/work environment - Development opportunities (i.e. groups, workshops, training) - Values align with work/school
Family/Friends - Sense of responsibility to family/friends - Have relationships characterized by warmth and belonging	Community/Campus - Opportunities to participate - Affordable, accessible, and supportive resources - Community self-determination and solidarity - Religious/spiritual affilation

Table 2, Protective Factors (Adapted from CARMHA, 2007; Maglio, 2015a)

How to Ask

- Many individuals may seek support for their low mood, but find it hard to talk about suicidal feelings due to many reasons (shame, guilt, fear, stigma, others reactions etc.)

- When low mood is present, or you are aware of risk factors/warning signs of hoplessness but the student is not disclosing suicide, it is helpful to phrase the question in session to normalize ideation and feelings.

- *"I hear you are feeling hopeless, unmotivated, and have low mood etc. It's very common when individuals feel this way they also have thoughts of ending their life or feelings of extreme hopelessness, I'm just wondering if this is the case for you?"*

  Kinda… Sometimes… Yes...

3. Conduct an open and detailed enquiry

- In order to determine level of risk, we must as ask about:
  - Ideation
    - Frequency, Intensity and Duration
  - Plan
  - Intent

3. Conduct an open and detailed enquiry

Ideation	Determine the frequency, intensity and duration of ideation - Have you ever thought about trying to hurt yourself? - Was there a time where you wished you were dead? - Have you ever had thoughts of killing yourself? Thoughts of suicide? - How often do you think about suicide? - How long do these thoughts last for? Minutes? Hours? - How severe or overwhelming are these thoughts? - On a scale of 1 (low intensity) to 10 (high intensity) could you rate the intensity - Have you ever attempted suicide?

Table 3, Suicide Topics for Inquiry (adapted from CARMHA, 2007; SAMHSA, 2009)

3. Conduct an open and detailed enquiry

Plan	Be as specific with these questions; this information will be useful in constructing a protective plan. - Do you have a plan to hurt yourself? - Do you have a plan to kill yourself? - How do you plan to kill yourself? - Do you already have the means to kill yourself? - When do you plan to kill/hurt yourself? (Be specific with time frame) - Where do you plan to kill/hurt yourself?

Table 3, Suicide Topics for Inquiry (adapted from CARMHA, 2007; SAMHSA, 2009)

3. Conduct an open and detailed enquiry

Intent	Determine the likelihood your client is going to follow through with suicide. - Have you ever attempted suicide before? - When and how was the last time you tried? - Do you have any intention of acting on your thoughts of suicide? - How strong is this intent? - Do you believe your plan will succeed in ending your life? - What's kept you going in the past when you've had these thoughts? - What keeps you alive right now? What keeps you going? - Do you plan to kill yourself today?

Table 3, Suicide Topics for Inquiry (adapted from CARMHA, 2007; SAMHSA, 2009)

4. Determine the level of risk

No Risk	Mild	Moderate	High	Severe/Imminent
-No suicidal ideation or risk factors	- Limited frequency, intensity, and duration of suicidal ideation	- High frequency of suicidal ideation, moderate intensity and duration of suicidal ideation	- High frequency, intensity, and duration of suicidal ideation	- Frequent, intense, and enduring suicidal ideation
	- No plan	- Possibility of a plan	- Specific plan present	- Specific plan present
	- No intent	- Little to no intent	- Plausibility of intent	- Clear subjective (self-report) and objective (clinical judgment) intent.
	- Good self-control		- Access to lethal means	- Prepared access to lethal means - Impaired self-control or no inhibitions to committing suicide
			- Impaired self-control	
	- RF: few - PF: Moderate to High	- RF: some - PF: Low/moderate	- RF: Many - PF: Low/None	RF: Many PF: None

Table 3, Suicide Risk Chart (adapted from CARMHA, 2007)

Counsellor Response and Client Interventions

1. Depression
2. Risk of Suicide

Vicious Cycle of Depression Depression glasses skew individuals thoughts, feelings, and behaviours.

Even if the client doesn't feel differently at first, over time shifting behaviours and thoughts will promote healthier happier feelings.

What does your client notice first?

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Mobil:(+49) 151-28177666 E-mail: info@psychealth.de

Depression Interventions

Behavioural Therapy - Behavioural Activation for Change

Cognitive Therapy - Cognitive restructuring for Balanced Thinking

Dialectal Behavioural Therapy – Distress tolerance and emotion Regulation

Behavioural Activation for Change

Activity Avoidance in Depression

Decreased involvement in activities due to lack of enjoyment

Concerns about judgement by others may also lead to avoidance

- E.g. "People with think that I'm a 'downer."

Avoidance is problematic because client no longer participating in activities that might improve mood (e.g. spending time with friends, exercise, etc.)

Behavioural Activation

Step 1: Start by writing down what you do on a daily basis without making any changes to routine

Notice any activities that lead to improvement or worsening mood, e.g. being in bed all day vs. taking a shower

Rate mood before and after activity (e.g. scale of 1-10)

Step 2: Reflect: Consciously increase activities that improve mood, decrease activities that make you feel worse.

Brainstorm more positive activities to consciously engage in

- Enjoyment/pleasure
- Accomplishment/small goals
- Closeness to Others

(Acreman, M., Thomas, K., Persall, N., 2014)

Behavioural Activation: Happy Hormones

DOPAMINE
THE REWARD CHEMICAL

- Completing a task
- Practising self care
- Eating food
- Celebrating little wins

OXYTOCIN
THE LOVE HORMONE

- Playing with a dog
- Playing with a baby
- Holding hands
- Giving a compliment

SEROTONIN
THE MOOD STABILIZER

- Meditating
- Running
- Sun exposure (wear an SPF!)
- Walking in nature

ENDORPHIN
THE PAIN KILLER

- Laughing
- Essential oils
- Dark chocolate
- Exercising

Activity Scheduling

- Make a commitment to do one enjoyable item each day – even if it's just for a few minutes a day.

- Accomplishments or goals must be realistic, small, obtainable, and specific. Must consider current motivation level.
  - This week I will eat healthy and exercise every day. NO.
  - This week I will eat fruit and yogurt for one meal a day, and go for a walk at least once during the week. YES

Cognitive Therapy for Balanced Thinking

Automatic Thoughts and Depression

Thoughts trigger changes in mood and are also the result of specific mood states

Occur automatically and therefore chain of thoughts may not be in conscious awareness

Automatic assumption is that they are 100% true and acted upon accordingly

Depression: "I'm an idiot for missing that question. No one likes me. I'm hopeless. I should be able to do X, Y, Z like everyone else…"

- We all make generalizations in our thinking. If we thought about everything we did consciously we would spend too much time everyday thinking about things that are second nature to us!
- Depression – we develop patterns of thinking (unhelpful thinking styles) that are inaccurate and get in the way of our happiness.
- These thinking styles are based more in how we FEEL than reality.

(Acreman, M., Thomas, K., Persall, N., 2014)

Unhelpful Thinking Styles

All or nothing thinking

Sometimes called 'black and white thinking'

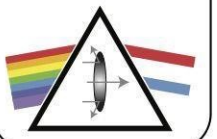
If I'm not perfect I have failed

Either I do it right or not at all

Over-generalizing

Seeing a pattern based upon a single event, or being overly broad in the conclusions we draw

Mental filter



Only paying attention to certain types of evidence.

Noticing our failures but not seeing our successes

Disqualifying the positive

Discounting the good things that have Happened or that you have done for some reason or another

That doesn't count

Jumping to conclusions

There are two key types of jumping to conclusions:

- Mind reading (imagining we know what others are thinking)
- Fortune telling (predicting the future)

Magnification (catastrophisation) & minimisation

Blowing things out of proportion (catastrophizing), or inappropriately shrinking something to make it seem less important

Emotional reasoning

Assuming that because we feel a certain way what we think must be true.

I feel embarrassed so I must be an idiot

should must

Using critical words like 'should', 'must', or 'ought' can make us feel guilty, or like we have already failed

If we apply 'shoulds' to other people the result is often frustration

Labelling

Assigning labels to ourselves or other people

I'm a loser
I'm completely useless
They're such an idiot

Personalisation

"this is my fault"

Blaming yourself or taking responsibility for something that wasn't completely your fault. Conversely, blaming other people for something that was your fault.

Balancing Thinking

- Strategy moves beyond positive self talk and "fake" positive statements
- The goal is to create a more balanced thought, so we react in a more neutral way to a situation, vs. only negative or only positive.

thought record.

Situation	Mood	Thoughts	Thinking Error	Evidence for the Hot Thought	Evidence Against the Hot Thought	Alternative/ Balanced Thought	Re-rate Mood
Wake up, don't get out of bed Who? What? When? Where?	Sad 50% Hopeless 30% Angry 20% What did you feel? Rate each mood: (0 to 100%)	This day is going to suck Im going to get nothing done Im so lazy There's something wrong with me Circle the 'Hot' Thought.	Overgeneralizing Catastrophizing Labelling Personalization	Staying in bed Not doing school work I need to finish	Worked on assignment yesterday Am I lazy ALL the time? NO! Maybe im tired. Helped friend this week	I might be having a tough morning because Im tired, but that doesn't make me lazy. It would help me more to think of what I can do for myself this morning vs. putting myself down. Write an alternative or balanced thought.. Rate how much you believe in each alternative or balanced thought. (0 to 100%)	Kind 10% Sad 40% Hopeless 10% Re-rate the moods listed in column 2, as well as any new moods. (0 to 100%)

STOP !

Just pause for a moment

TAKE A BREATH

Notice your breathing as you breathe in and out.

OBSERVE

- What thoughts are going through your mind right now?
- Where is your **focus of attention**?
- What are you reacting to?
- What sensations do you notice in your body?

PULL BACK - PUT IN SOME PERSPECTIVE

- What's the bigger picture?
- Take **the helicopter view**.
- What is another way of looking at this situation?
- What advice would I give a friend?
- What would a trusted friend say to me right now?
- Is this thought a **fact or opinion**?
- What is a more reasonable explanation?
- How important is this? How important will it be in 6 months time?
- **It will pass**.

PRACTISE WHAT WORKS - PROCEED

- What is the best thing to do right now?
- Best for me, for others, for the situation?
- What can I do that fits with my **values**?
- Do what will be effective and appropriate.

•https://twitter.com/LotusPetalPND/status/776138358976307200/photo/1

Use *EAR* as a reminder to *listen* – to yourself!

When you experience a negative *mood* – sad, irritable, depressed, angry, etc. – remember ***EAR***:

E **– Event**	What *Event* has influenced your mood? What *Situation*, *Behaviours*, and/or *Physical State* have had an impact on your mood?
A **– Automatic Thoughts**	What are your *Automatic Thoughts?* Are they *Accurate*? Do you recognize any *Thinking Errors?*
R **- Response**	Is your *Response* appropriate? Can you think of more *balanced thoughts?* Can you make beneficial changes to your *Situation, Behaviour,* or *Physical State*?

(Acreman, M., Thomas, K., Persall, N., 2014)

DBT for Distress Tolerance/Emotional Regulation

Distress tolerance

- IN THE MOMENT exercises to practice, when feelings are intense and extreme.
- Skills that develop the client's tolerance and ability to accept emotional events vs having emotions take over control.
- Learn to tolerate emotions vs. fighting and struggling with them.
- Learn healthy behaviours vs. unhealthy coping mechanisms.

- TIPP
- ACCEPTS
- IMPROVE
- Hope box

De-escalate intense situations with TIPP

Temperature – Change the temperature of your body	go outside, take a cold shower, hold a cold icecube, run hands under cold water, splash face with water
Intense exercise	Jumping jacks for 2 minutes, run on the treadmill, do pushups, dance around
Paced breathing	Box breathing, rectangle breathing
Progressive Muscle Relaxation	Tense and release muscles to promote relaxation

(Linehan, 2014)

Distract in the moment with ACCEPTS

- **A**ctivities (keep busy, i.e. go to the park, exercise, watch a movie, hobbies
- **C**ontributing (get your mind off yourself, i.e. volunteer, listen to someone else's problems)
- **C**omparisons (Remember a time in your life you were worse off, how did you get through that?)
- **E**motions (do something that makes you feel different, i.e. if sad, listen to upbeat music, if angry, watch a comedy)
- **P**ushing away (block out thoughts/feelings, i.e. put the problem/issue in a "box" and place it on a shelf)
- **T**houghts (distracting thoughts, i.e. 5-4-3-2-1 exercise with sound, sight and touch)
- **S**ense (be aware of your senses, i.e. take a cold shower, go outside, open the freezer)

(Linehan, 2014)

Improve the moment with IMPROVE

- **I**magery – calming fantasy, improved mood, happy times, emotion leaving body
- **M**eaning – positive aspects of hurtful moment, inner kiddo, remember values
- **P**rayer – ask for strength or guidance from a higher source
- **R**elaxing – massage, yoga, stretching, bath, change facial expression
- **O**ne thing to focus on – meditate, hobby
- **V**acation – nature, drive, walk etc.
- **E**ncouragement – what would you tell a friend?

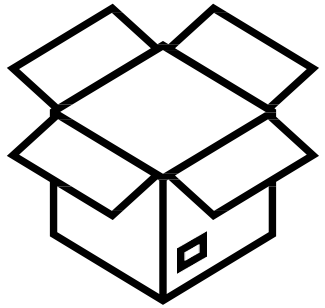
(Linehan, 2014)

Self Soothing "hope" Box

Create a hope box with client in session that contains objects that the client chooses to put in and that are life affirming and self soothing. (i.e. Self care items that help to promote better mood, and self-soothing tools).

Items in a hope box may include:

- Letters or printed emails from loved ones that mean a lot to the student
- Inspirational quotes (religious or otherwise), articles of hope
- Photos of special times and moments they have had, or hope to have
- Photos of loved beings (people, pets)
- Small objects of meaning that bring hope or soothing
- Essential oils/candle that the student enjoys smelling and finds soothing
- Comfort snacks
- Anything else that reminds student of reasons to stay alive



(Freedenthal, 2013)

Suicide Interventions

For All Risk levels

- Create a safety plan. Revisit when/if level of risk changes.
- Assess the client's immediate environment (lethal means/weapons), restrict access.

Recommended Treatment options (Moderate-High; High)

- Depression Interventions
- Handouts: *Coping with suicidal thoughts*
- Resources: Emergency or Crisis (24/7)

Safety Plan

1. **Do the following activities to calm/comfort myself (i.e. relaxation technique, physical activity) (approx. 4)**
2. **Remind myself of my reasons for living (approx. 4)**
3. **Call or text a friend or family member to distract me**
4. **Call or text a friend or family member to talk my issues out**
5. **Professionals health care provider or agencies I can contact during a crisis (approx. 2)**
6. **Go to the Emergency Room at the nearest hospital.**
7. **If I feel that I can't get to the hospital safely, call 911 and request transportation to the hospital. They will send someone to transport me safely.**

(Samra & Bilsker, 2007)

How to work with the client at different stages of risk

Mild-Moderate	Moderate-High	High	Imminent
Non-Directive; client creates safety plan; explore reasons for living; look for strengths, protective factors; validate and normalize symptoms *What can you do tonight to make you feel better?*	**Cooperative**; joint brainstorming; involve support; explore protective factors, coping strategies; explore suicidal fantasy; empower student	**Directive**; clinician takes charge; family members/caregivers supervise; increase session frequency; give resources; explore future plans *Is there anything that can keep you alive for the next 24 hours?*	Extend the current session/stay with client; call 911 or get client to a hospital *Do you think that you can keep yourself safe outside of session? NO.*

Table 3: Treatment Plan by Risk Level (adapted from CAMH, 2010; CARMHA, 2007)

Handouts

- Coping with Suicidal Thoughts (Samra & Bilsker, 2007)
- Safety Plan (Samra & Bilsker, 2007)

- Emailed to you before/after presentation today

Resources

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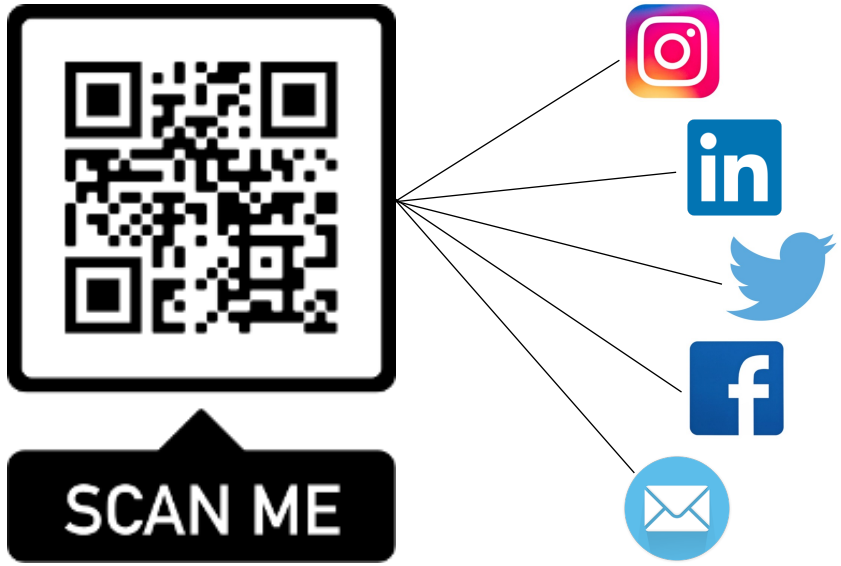

Thank You for Joining Us!

Christina Ruggiero, RP

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