Welcome to 30 Brave Minutes, a podcast of the College of Arts and Sciences at the University of North Carolina Pembroke. In 30 Brave Minutes we'll give you something interesting to think about. Our program is now available on PodBean and iTunes making it even easier to find us. The topic for today is Suicide Prevention and Awareness. In this episode the Dean of the College of Arts and Sciences, Jeff Frederick is joined by Lyndee Horne, Director, and Charla Suggs, Assistant Director of the UNCP Counseling and Psychological Services. Get ready for 30 Brave Minutes.

FREDERICK: If the numbers are right, somewhere in this country 123 people will end their life today. All told, nearly 45,000 people do so each year in what has become the tenth leading cause of death in America. Sometimes, like in the case of Robin Williams, Kate Spade, Kurt Cobain, or Anthony Bourdain, the names are famous and so the television coverage goes wall to wall as we ponder the loss. Yet in every case the questions remain long after the funeral is over. North Carolina is 38th in the United States in suicide, so this issue cuts close to home in so many ways. For every one person that dies by suicide, 25 others attempt it. For every death, 11 end up in the hospital, sometimes for long term care. Men are more likely than women to end their life; but women are much more likely than men to attempt. Middle-aged white men are actually among the very highest to complete death via self-harm. Those over the age of 85 are surprisingly the second highest. People end their life in any number of ways, but the most common is with a firearm. Research from the journal, *Annals of Internal Medicine*, indicates that having access to a gun in your home makes the likelihood of a successful suicide attempt significantly greater. But the real questions above the cold hard numbers are why and what can be done?

Suicidal thoughts and behaviors can be reduced through treatment, counseling, and various forms of support. In short, it seems that people attempt to take their own life when they feel that the pain or burdens they are feeling have created a mountain of hopelessness that cannot be overcome. Research indicates that up to 90% of suicides were completed by people who faced substance abuse or mental health disorder challenges, but research changes. Treating those chronic and difficult issues can make a huge difference, and counselors, experts, therapists, professionals, and others are highly successful in using their skills to treat many of the underlying problems. Help can be found. The National Suicide Prevention Lifeline provides free, confidential suicide prevention and intervention services 24 hours a day, 7 days a week. If anyone is feeling like they need to speak with someone you can call toll-free, 1-800-273-TALK (8255).

What can be done? Let's start with warning signs that include actions like talking about wanting to die, suicidal ideation, talking about feeling hopeless or having no purpose, or feeling trapped and in insurmountable pain. Folks rarely end their life because of a singular reason—it's usually a combination of factors many of which few others in their life realize at any given moment, or few understand the true depth of despair being experienced by someone who might be in the same classroom as you or in the same work space, maybe waiting in line next to you while getting ice cream, or even stopped at the same traffic light. These factors include financial and emotional pain, grief, isolation, substance addiction, sleep deprivation, and maybe a history of

family mental illness or violence. But again, it’s never one thing. It’s many. And most importantly, there’s help.

To help us understand these warning signs, how to help, what to say, and what to do, we have LynDee Horne, Director of the UNCP Counseling and Psychological Services and Charla Suggs, Assistant Director. Welcome.

HORNE AND SUGGS: Thank you.

FREDERICK: How much do we know about suicide? What can we say definitively about it in terms of basic understanding?

SUGGS: Much of what you said in your introduction is absolutely accurate, but we also know that due to some slow progress and research over the last hundred years, we don't really know a lot of new things about it. Our understanding of suicide is about the same now as it was about a hundred years ago. Because in the culture in our country we are devoting more resources to other issues than suicide, but like the recent celebrity suicides that you mentioned earlier, this does give us a forum to talk about it and hopefully begin to change those trends just a little bit. Lyndee and I specialize in treating college students and we do know that suicidal ideation tends to peak somewhere around the age of twenty to twenty-four. We also know that untreated depression is a leading cause of suicide. That is something that really touches our hearts in a special way because we can do something about that. Depression is a real illness and it is really treatable.

FREDERICK: Well, let's start with just a broader understanding of depression. How would you all define and identify that and, before we get deeper into understanding suicide, how can we be on the outlook for depression signs?

HORNE: I think we have to talk about what the difference is in situational depression or having a moment, a human moment when we feel down about something. That's very normal. It happens to all of us in our walks of life.

FREDERICK: Just this morning, by the way.

HORNE: Yes. Life can be frustrating sometimes and disappointing, but it is when those symptoms of sadness, lack of motivation, maybe sleeping longer or not being able to sleep enough, just a constant nagging of feeling down, or wanting to withdraw. When those types of symptoms continue to last and when they last longer than two to four weeks, when they start interfering with your ability to enjoy your work or your relationships, or things in your social environment, then that is the place when we really need to start looking at "Is this a mental health concern?" or "What are the things we can do to treat that?" As Charla said, it is extremely treatable. There are many evidence-based practices now for several of the mental health diagnosis that coincide with suicide and suicide ideation. That is one thing that, you know, while Charla mentioned a lot of research or what we know about suicide hasn't changed that much, what we do know, even in the statistic that you stated, is 90% of those that complete suicide, they did have a diagnosable mental health concern. We do have treatments for those things. It is good news. I have heard many, many people say at times when they are talking about suicide

that this is the number one preventable disease and I believe that. We are passionate about talking about it and we get to also be the people who treat that, and get to walk with people through that. We are passionate about that in a lot of ways.

FREDERICK: I want to make sure we talk about success stories and the positive nature of the treatment, but you brought up some of the warning signs related to depression. At what point in time does a basic form of depression move into the area where suicide or warning signs of suicide are present? And what might be some of those warning signs?

SUGGS: I think it is important, too, to understand that not every person who experiences an episode of depression or who feels depressed is going to be suicidal. Even more so, not everyone who experiences clinical depression is going to experience suicidal ideation as part of the experience of that illness. We also know that many will. It is important to understand that, but Lyndee mentioned too, that when we are talking about the experience of depression and most people know what it feels like to feel depressed at times, when it gets to the point where that is lasting longer than two weeks and it is intense enough to interfere with your ability to engage life and you are starting to experience pain that overrides our natural tendencies and mechanisms that are innate and keep us alive, then we know there is a problem. There is a time at that point to reach out for help, because help is available if you know where to find it.

FREDERICK: So to jump in here for just a second, all of us experience brief downturns and our affect or our behavior, but if those persist that is the time where something needs to be treated.

HORNE: And the difficult thing is with medical concerns. There are a lot of tests that we can do. Blood tests, CAT scans, things like that, to determine what the illness is, but when we are dealing with mental health issues it is a bit more abstract, which causes people to sometimes believe 'I should be able to handle this on my own,' or 'there is nothing really wrong with me,' or 'I'm weak.' Sometimes the people that love them, out of fear, reinforce those messages. So it is a little harder to understand or wrap your mind around a mental health issue, but we do know for absolute certain that these issues are real and that they are treatable and they are also medical concerns. Just because they are affecting our mental health does not mean that it is going to happen independently from the body.

FREDERICK: So part of what prevents people from getting treatment is the sense that it is their own fault, they should just pull themselves up by their bootstraps, snap out of it, and then they don't get the professional help they need. By blaming themselves do they make some of their symptoms worse?

SUGGS: They absolutely can and in our world we call that stigma. There is that proverbial black dot that we fear is going to follow us into a counseling center or follow us when we go to a pharmacy to fill a prescription for a psychotropic medication that is going to rub the edges off the symptoms long enough to feel better so that you can get better. It is not real but the fear that we are going to be judged in a particular way or viewed as weak or viewed as sick, or in some ways less than what we desire to be, is a huge barrier. We really work to advocate in our field to increase mental health literacy so that stigma decreases.

FREDERICK: Nobody would think twice about going to see a physician for a broken leg, but if we are in a state of depression, somehow we create that stigma that tells us we shouldn't go get help, we should be able to figure this out ourselves.

HORNE: Absolutely.

FREDERICK: Any other specific warning signs where the depression has gotten to the point where suicide is becoming something that is beginning to be thought about?

HORNE: I think one thing that I would mention, because I think it is something that sneaks up on people, or they want to call it something else, is anger and irritability. Specifically in men, they may not feel the sadness, they may feel disconnected, but a lot of that emotion is coming out in really intense anger and frustration and it may catch them by surprise when the suicidal thoughts may come because they haven't felt sad. I think that is something that I see particularly in men, that are surprised, or it will take them longer to even think about seeking treatment because this is just an anger issue - I just need anger management, or this isn't depression. What is that and how do those things even correlate? I think that is one other thing that I would mention specifically that I think gets missed.

FREDERICK: So depression can manifest itself in tons of different symptoms. For one person it is sadness or for another person it might be rage or anger. So, on a practical level, advise all of us non-professionals, if we know somebody who is experiencing some form of depression, what should we say to them? What are ways in which we might get them to seek treatment, without making the problem worse in some way?

SUGGS: I think it is important to know that simply being there and having a consistent presence in someone's life in a supportive way cannot be overstated. It is incredibly valuable. So when we are in touch with a loved one and we start to perceive that the depression is going in a direction where that person might be suicidal, the number one thing that we don't like to do in this culture is talk about it. But we must talk about it. The research is telling us time and time again that when you ask a person if they're thinking about killing themselves, taking their lives, or contemplating suicide, it does not plant the suggestion in their mind. In fact, it opens something akin to an escape hatch for a little release of tension, because that person knows that they can actually talk about it. Whether or not that person does talk about it is a separate issue, but simply by asking the question, "I understand that this pain is really significant. Has it gotten so deep that you are thinking about ending your life? Have you thought about suicide?" just creates an opportunity for that person to talk. So, we have to ask the question and then, the most difficult part, I think, of asking the question is not actually fearing that you are going to choke on the words, it's waiting in the silence after the question is finished for an answer that you might not want to hear, or you might be afraid to hear. I mean, it's scary. Suicide, we are talking life and death, so it is okay and it is normal, and it is natural to feel reticent. It is natural to be afraid of that conversation. What's not okay is not to have it. If you can't have it get that person to someone who can have that conversation with them. It is okay to talk about it and we know that is going to help. That is the first step in treatment.

FREDERICK: So a friend who sees someone suffering doesn't have to do anything heroic. They just need to start a conversation. "Let's go meet for coffee" or "how are you doing?" "Is the pain you're experiencing so much that you are thinking about hurting yourself?" And then wait for that person to respond. What else can people do if they begin to see some of the warning signs, just as a good, common, ordinary piece of advice for how we interact with a pretty broad circle of friends and coworkers?

SUGGS: We do know that suicidal ideation tends to diminish when people feel connected. It tends to increase when people feel a lack of connection. So, once again it goes to that consistent presence in someone's life, checking in on them, sending a card, sending a text reminding them that you are here. Really, I keep saying the word connected, but it really does go back to that sense of staying connected with an individual and being mental health literate yourself. Knowing where the resources are. I know that one of the shocking things is that many college students in various studies report that the number one reason that they don't use their college counseling center is because they don't know it's there. We are the best kept secret on campus that nobody is trying to keep. We are in Freshman Seminar. We are in New Student Orientation. We are in front of students as much as we can be, but much of our work takes place in private behind closed doors in a confidential setting. It has to be that way. Just knowing that there is help available and knowing there is the 1-800-273-TALK lifeline for suicide prevention. There is always someone available that can talk to you and that it is always okay to get help.

FREDERICK: Including your team on the second floor of the Brave Health Center, open and available. So, if you see a coworker who seems isolated or not being included, occasionally something as simple as just saying, "Hey, we're all going to lunch. Would you like to go with us?" might be able to help us to bring somebody in a little bit.

*We'll return to our program in just a moment. UNCP and the College of Arts and Sciences are changing lives through education. To learn more about our 16 departments, college highlights and news, explore our website. You can also support our department programs by clicking on the donate button. Additional news and events may be found by following us on FaceBook at UNCP College of Arts and Sciences. And now you can subscribe to 30 Brave Minutes on Podbean and iTunes. Remember wherever you hope to go, whatever you plan to do, you can get there from here.

FREDERICK: Talk a little bit about something more contemporary. The rise of social media: how has that helped people to feel worse about themselves or somehow get disconnected from dealing with the symptoms of depression or of potential suicide?

HORNE: I think we could go both ways with this discussion. Technology, in many ways, is a double-edged sword. Yes, comparison happens more frequently. Yes, we have a certain persona in social media that is portrayed, that may not give people the exact reality, or they don't feel like other people are suffering. And people are also, many times, more willing to share on social media than they would be. It is a little less risk than saying it out loud in front of someone in a room. I actually can appreciate what social media has done for people who are feeling bad. Suicidal comments are made on social media platforms and many times you will see their followers or their friends start saying, "Hey are you okay?" "Hey I am here for you." and that is a

way for them to get support when maybe they are not willing to walk to the second floor of the Brave Health Center. So yes, there are places where you could feel worse about yourself in some ways, but I am seeing people being willing to take a chance there when they won't walk into a mental health counseling center. I am encouraged by that and I know we have mentioned the phone number for the national hotline, but there is also a text. So you can text TALK to 741741, so even that is a place where if you are not ready to voice it you can still write it. I think that is the place where so many times, even in therapeutic interventions when we are not ready to say it out loud we can write it down. I think social media has been able to be a platform where people can actually write it down and get help when they may not have done that before. There are all different kinds of liabilities in that but I am choosing to see it as helpful and that it is a place to continue to decrease stigma and keep the conversation going. We have avenues that we have never had before to keep this conversation going and that, to me, is exciting about this field.

FREDERICK: That is. That is good. Digital connections may not be physical ones but they are real and they can have meaning to get people to some help. So let's talk a little bit about that help and the therapeutic intervention which you referenced a minute ago. How do professionals like ya'll help people. What are the techniques? What are some of the tools? Are there opportunities for medication to assist with some of the underlying issues? How do you use the toolbox that you have to help people in these spirals?

SUGGS: We have so many tools in that box and that is a very encouraging place to be in our field right now. Absolutely there is a place in this conversation for medication and so many people don't want to have that part of the conversation, but like you said, nobody hesitates to take medication if they have been diagnosed with cardiovascular disease or diabetes, so why are we treating the mental health diagnosis differently? It is because we understand them differently and we view them differently. We are really working to try to close that gap. There is a place for medication because medication can help you feel better. It can stabilize brain chemistry. It can correct some of the problems like that organic depression that lives in the body cause. We also have other therapeutic interventions, too. We know that the research has substantiated time and time again that medication with therapy works exponentially better than medication on its own. Therapy works pretty well, too, but a combination of the two is often exactly what is in order to treat depression. In terms of therapeutic interventions, there are a lot of different talk therapies that we can use. Giving somebody a safe, neutral place to simply talk about things that they never wanted to say out loud, or give them a place to write it down like Lyndee said, if they are not ready to say it out loud, can acclimate them to the idea that it is okay to have the conversation. We know that a lot of the pressure is going to subside just because we provide that forum. We can also look at the antecedents. If we are interested in addressing anger because we understand that that depression is manifesting. We can manage anger while we are getting to the cause of what is bringing the anger because that root source is really what needs to be addressed many times for many people. In addition to talk therapy, because some people don't want to come to therapy and talk about their feelings. That is kind of one of the stereotypical understandings of what therapy is. Oh, you just go talk to somebody but that doesn't really help. For many people they do need something in addition to that and one of the things that I get to do, and I can't believe I have found a way to get paid for doing this, is not only sit with people in their pain, and talk about it, but also go straight to the body. We know that depression affects the body, too. We know that the human body is an amazingly accurate record-keeper of everything

that has ever happened to us. Sometimes just the tension in the imprints that are left in our muscle memory, having a way to get out of the body can alleviate so many of the symptoms and cause people to feel better very, very quickly. Tackling depression from multiple angles is one of the best practices there is. We can treat the body, we can treat the mind, we can talk it out with the heart, we can involve the medical practitioners and get medication when we need to, but there is just so many things that we can do.

FREDERICK: The value of getting professional help is that you guys have so many tools in the toolbox. For some it might be play therapy, for someone it might be art therapy, for someone else equine therapy. Ways to breakdown some of the barriers. For others, it might be some physical things they would go through to help put those tension points, so you guys are really great at identifying which tool to use for each person to help them work through some of their issues.

HORNE: Absolutely. And what is right for each person, considering where they are in their journey, because one of my specialties is therapeutic yoga and using that to address a wide range of mental health issues, not just depression. So, yes, some of the more physical activities and some of the more connectedness with nature, the mindfulness meditation. There are so many different tools that we have.

FREDERICK: And then moving forward there are so many coping mechanisms that a person suffering from these depression symptoms could go through for the times where they are not in your presence, or they are not getting therapeutic intervention. There is stuff that folks can do all week long.

HORNE: Yes. Whether that is a goal of some type of social connectedness and being able to be held accountable or having that extra motivation of saying, "hey, connect with somebody in a genuine way this week, and we'll talk about it next week," or whether that is some type of a physical exercise or a specific journaling around a topic that has come up that we can talk about more as they process that. Different ways to process left brain and right brain thinking. So there is many, many different ways to cope in between sessions while you are working on whatever is diagnosed.

FREDERICK: And understanding that all patients and clients are different, right? There are plenty of success stories out there. If you will go get help then some of these depression symptoms can be mitigated or arrested and people can continue to lead productive lives. Not that they wouldn't have momentary periods where they are feeling a little melancholy, but you can get help.

SUGGS: I think we probably have more success stories, but you can't measure prevention because there is nothing that has happened to give you a measuring point. I think it is really important to understand that most people who seek help for depression actually get that help and there are so many success stories. But it is also such a private journey that there are few people willing to create a platform to talk about it publicly. That's okay. That's okay to keep it close to home. It is also okay to be an advocate through your personal story.

FREDERICK: Let's talk a little bit about how you all cope dealing with people who are facing all of these difficult situations every day. How do you provide self-care? How do you not allow shouldering so many of the burdens of other people to overwhelm you?

SUGGS: That's a great question. I was asked once to describe my job in one sentence. My answer was I hold pain. That's what we do all day. We do a number of other things, too, and we have a lot of fun with our clients. It's not all deep, heart-wrenching conversation, but much of it is. That is our primary job and not everybody can do it. Not everybody is equipped with the grace to do it, but we also consider it an honor and privilege to do it. It doesn't come without a cost. There are several times in a week that you can find us in one another's offices, not talking about a particular client, but talking about a particular experience that we are having and so we lean on each other. We try really hard to leave our work at work and we go home and engage with our families and we know the signs and symptoms. We know when we are starting to lose interest in the things that we used to enjoy, too. I mentioned yoga before, but yoga has been really instrumental in my life in giving me a place to work out a lot of that tension and a lot of the stories that I hold in that space that tends to reside in my own body. Also, for me personally, faith is the biggest part of what keeps me going, because I know that my faith allows me to shift that burden to someone, whose shoulders are much better equipped to handle that than mine are. I think that every professional has to have those outlets to be okay and engage in life and separate work.

FREDERICK: Be connected to other people and be connected to some other greater sense of purpose.

SUGGS: Absolutely. Yes.

FREDERICK: Be connected to the things in life that fill you up, whatever they are.

SUGGS: Yeah, I was going to say, for me, it is connected to my family, but I am a big nature person, so being able to connect with nature and just breathe fresh air and be able to just get a different perspective of the world. Every time I'm in nature I feel so small and I like that feeling. There are things bigger than me, so I really love to do that and for me, connecting with, for lack of a better way to put it, innocence. So, connecting with my daughter and being able to be around other people that remind me of the not-heavy stuff, but the really fun stuff in life, really does help energize me and keep me going.

FREDERICK: Everyone kind of knows what those things are that fill you back up, but sometimes we get so busy in our day that we forget to do those things: some large and some small that sort of get us back to level. What would you advise us to say to people who have lost someone due to suicide? What words should we use? What words should we not use when talking about it?

SUGGS: I think it’s okay to use minimal words or even okay to not say anything at all sometimes. Grief, when dealing with suicide survivors, is extremely complex and it's going to take a while for those pains to heal. A person that has lost someone to suicide is going to experience so many different intense emotions and they are going to come in waves. So, I think

just letting that person know that you are here. If you are going to use words, I think that the best words to start with would be something along the lines of "I'm here. What do you need? How can I help? Do you want to talk, and if not, I will just sit here. I can witness your story and be a part of this pain, and walk through this journey with you without saying a word, if that is what you need right now." I think we put too much pressure on ourselves sometimes to have the words to say. The truth is sometimes there are no words.

FREDERICK: Right.

SUGGS: But our presence matters.

FREDERICK: And there is certainly help for people who have experienced the sudden death of a loved one, that they can get care. There are therapeutic interventions to help them go through the long-term process of coping with that as well.

SUGGS: They should. They should seek care for themselves professionally and through the support of their family and friends and through their own self-care. Understand that patience with others and also patience with self is necessary.

FREDERICK: This has been very informative. There is reason to be positive because there is help available and there are no great acts of heroism needed by friends or coworkers. Just simply get connected. Have a conversation and encourage to think and to go find the help that they need.

HORNE: We call that courageous conversations.

FREDERICK: That's great. I love that. Well, if you need a courageous conversation with one of our experts here on campus, they can be found on the second floor of the Brave Health Care Center. Remember help can be found. Again, the National Suicide Prevention Lifeline provides free confidential suicide prevention and intervention services twenty-four seven. That number 1-800-273-TALK (8255). Thanks Lyndee and Charla for a fascinating and thoughtful conversation. Tune in next time for another edition of 30 Brave Minutes.

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