Chi Sigma Iota
Chi Omega Chapter
Quincy University

The Insight

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Depression and Suicide: Special Issue Introduction

By Andrea Fifield

Depression and suicide are public health issues, and they are nothing new. They are, however, very difficult issues to talk about. Many people who suffer depression don't discuss it openly, either because it is simply too personal, or because they worry about the stigma associated with any mental health condition, no matter how common it is. Similarly, those who have lost a loved one to suicide often find the topic too painful to discuss. However, in August of 2014, Robin Williams committed suicide, and his death brought the issues of depression and suicide into the public discourse once again.

In the public debate that was waged online and in social media, many had sympathy for Mr. Williams and framed his death as tragic, while others viewed his death as a selfish decision. This debate only intensified three months later, when Brittany Maynard, a terminally ill 29-year old woman, chose to end her life under Oregon's "Death with Dignity" law. Even among our students here at Quincy University, you could observe the internal conflict during class discussions, as students clearly had empathy for someone who is in so much pain, but were simultaneously very uncomfortable with the idea of suicide. While the 2014 ACA Code of Ethics provides some guidance for addressing end of life decisions with clients, it cannot alleviate our discomfort or change our values related to death and dying.

Here at QU, these recent high profile suicides inspired our students to engage in advocacy and public awareness efforts. Some of our MEC students assisted our on-campus counselors with National Depression Screening Day in October. Others created informational flyers about depression and suicide, along with university and community resources for those who need help, which were posted around campus. Additionally, our Chi Omega officers have chosen to contribute articles for this newsletter. In the following pages, readers will be provided with general information about depression and suicide, as well as information on how depression can impact specific populations.

As counselors, we *will* be faced with clients suffering from depression, and some of these clients may reveal suicidal ideation. It is our job and our ethical duty to help these people to the best of our ability. The first step in that process is to be knowledgeable of the issue. Our special issue contributors hope that the information in the following pages will provide you with some of that knowledge.

Inside this Issue:

The Insight

Depression and Suicide: The Facts

By: Emily E. Lamb

As a society, we have begun to accept mental illness as part of human function. We often joke about stress as we talk about the busy world we live in. What we overlook, however, is the severe impact stress and other mental illnesses can lead to when not properly assessed, acknowledged, and addressed. With fast-paced lives, and a tendency to rely on "quick-fix" answers to our problems, the struggle to succeed and pressure to appear successful are always looming over us. According to the Center for Disease Control, suicide, or intentional harm to self, is among the top 10 causes of death as of 2012. Each year nearly 40,000 people in the United States alone will take their own lives. That equates to over 100 people per day.

Over 100 people per day commit suicide.

Just as shocking is the 8% of persons over the age of 12 who have reported, diagnosed cases of depression.

Overall, we see 10% of females in this category reporting depression and 6% of males. 1 out of every 10 female s over 12 in our country!! As we look at higher age groups, we see that the distribution changes slightly around middle age (40 -50) with men increasing to around 7% and women increasing to 12%. No matter the age group, women are always reporting at higher rates. As mental health professionals, it is important that we remain aware of the mental illness statistics in our society and keep up to date on the pressures and stressors that are often reported in connection to these illnesses. This will allow us to focus our efforts in directions most beneficial to our clients.

SUICIDE RISK FACTORS

CDC.GOV

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

The Insight

Post-Partum Depression Vs The Baby Blues

By: Shandi Joubert-Kanz

Post-partum depression (PPD) is a very real and debilitating disorder that causes many women to hate being a mother. Mehta and Mehta (2014) reported that it occurs in 10-15% of women after delivery. While this is a disorder that is diagnosed frequently it requires the mother to seek out medical attention and this is difficult to do. Some of the clinical risk factors of developing PPD are as follows: Unwanted or unplanned pregnancy, Depression or prenatal anxiety, and past cases of PPD (Mehta & Mehta, 2014). While these factors are potential factors they cannot be considered an exhaustive list and should not be the only factors considered when making a diagnosis.

Other factors that affect the potential for developing PPD are psychosocial, marriage related factors and child related factors. Mehta and Mehta (2014) discussed that the having little support or conflict during pregnancy can cause PPD. Any issues in the marriage directly related to the husband are potential factors as they can raise the stress level of the mother during and after pregnancy. And factors related to children include: Health related problems, feeding difficulties, and exhaustion after child birth. Each of these factors can occur without PPD but the more factors a mother presents with, the higher the odds for having PPD.

According to the DSM-5, the symptoms of PPD present in the same way that major depressive disorder some of the symptoms that present are: depressed mood most of the day, insomnia or hypersomnia, fatigue or loss of energy nearly every day, and feelings of worthlessness or excessive or inappropriate guilt. With pre-partum onset the issues can start before giving birth and after. Approximately 50% of women with post-partum depression begin to have symptoms before delivery.

There is a misconception that PPD is not common and women who struggle with the symptoms may go long periods of time without treatment or may not seek treatment at all. For some it is possible to treat the symptoms with medication alone but it is recommended that therapy and medication happen concurrently.

While PPD is common it is often mistaken for the Baby Blues. The Baby blues is not in the DSM-5 but affects many women. According the American Pregnancy Association somewhere between 70-80% of women have negative feelings after what should be the joyous event of having a baby. The symptoms of the baby blues present similarly to that of PPD. Some of these symptoms are as follows: Fatigue, insomnia, crying or weepiness and mood changes. The biggest difference between PPD and the baby blues is the duration of symptoms. With the baby blues symptoms may occur for several minutes or hours per day but will decrease after about 2 weeks. PPD more often lasts into months if not longer when is left untreated.

Both PPD and the baby blues have real effects on women and should be taken seriously. The best path to take to keep yourself and your children safe is to seek help from professionals (general practitioner and therapists). If you or someone you know is struggling with PPD or the baby blues please get the services and help you need to overcome the symptoms.

Seasonal Affective Disorder
By Lauren Baker

Seasonal Affective Disorder (SAD) is a reoccurring depressive state experienced in a cyclical nature due to seasonal changes throughout the year. The onset of these depressive states is most commonly linked to the seasons of fall and winter whereas the offset of the depressive states is most commonly linked to the seasons of spring and summer. According to Kurlansik and Ibay (2012) about five percent of the U.S. population have reported to be affected by SAD each year. In addition, individuals affected by SAD report to be experiencing depressive symptoms for approximately forty percent of the year (Kurlansik & Ibay, 2012). It is also interesting to note the demographics that SAD tends to target, being that SAD, "tends to be predominant in women, particularly during childbearing years," (Kurlansik & Ibay, 2013, p. 607). A client with SAD will present with depressive symptoms, however, it is important for a counselor to make note of symptoms that reoccur in the cycles mentioned previously. This realization may help lead to a diagnosis of SAD for a client.

There are two types of seasonal affective disorder, the most common of which is winter depression. This SAD type is linked to an onset of symptoms in fall and winter and an offset of symptoms in spring and summer. There is also a much less prevalent type of SAD known as summer depression, which is linked to an onset of symptoms in the summer (Sato, 1997). Sato (1997) theorizes that the summer depression type may be linked to excessive heat. For the purposes of this article, I will focus on the winter depression type of SAD.

When comparing SAD to a non-seasonal depressive disorder, there are some similarities and differences in symptoms. Similarities in both a seasonal and non-seasonal depression are in the symptoms of hypersomnia (over sleeping), over eating (carbohydrate indulgence) and weight gain (Sato, 1997). Those with SAD seem to differ in symptoms such as suicidal ideation, in that this symptom is much less common in those with SAD compared to a non-seasonal depression. Those with a seasonal depression also tend to be less self-critical and be less dependent than those with non-seasonal depression (Sato, 1997). Questions considering how to distinguish between a seasonal and non-seasonal depressive type when seeing a client continue to be researched.

An abundance of research studies have looked for the possible causes behind SAD. Hypotheses suggested most heavily revolve around the amount of daylight available in the respective seasons. The relationship of daylight to SAD has been framed in terms of the amount of hours available for absorption and the resulting variation in the secretion of melatonin (Young, Meaden, Fogg, Cherin & Eastman, 1997). Melatonin is a hormone associated with increased secretion in the dark and is associated to

SAD—continued

maintaining sleep cycles. Another possible cause behind SAD has been related to circadian rhythms (Young et al., 1997). Changes in circadian rhythms are influenced by environmental factors, which may be related to the original theory of daylight hours that fluctuate during each season (Kurlansik & Ibay, 2013).

One of the most heavily accepted treatments for SAD is known as light therapy (LT). Kurlansik and Ibay (2013) describe light therapy as being a process that a client must commit at least thirty minutes to every morning during the months that they normally experience a heavily depressed state. The daily prescription of this treatment must be linked to a high commitment level from the receiver. Light therapy would require that the client sit within twelve to eighteen inches of a light that is a brightness of 10,000 lux and is a white fluorescent. Staring directly into such a light is not required, the client may spend the time doing something more entertaining such as reading, writing, or eating their breakfast. Rosenthal et al. (1984) conducted a research study that attributed light therapy as having the same effects as an antidepressant for those with SAD, lowering the subjects' symptoms of over sleeping and over eating. LT lights are manufactured to the public, with sites such as Amazon selling models such as Verilux's compact happy light which describes itself as lowering fatigue, increasing concentration and increasing overall productivity for its users.

Other research studies do not appear fully supportive of LT. Rohan et al. (2007) argue that LT does not provide a full remission of the symptoms associated with SAD, in that clients must continue to devote their time to the daily regimen to continue to reap its benefits. Rohen et al. (2007) also explain that LT is much more time-consuming (requiring a daily commitment) as compared to other forms of treatment, such as cognitive behavioral interventions. Many clients fail to follow through with their own LT treatment (Rohen et al., 2007). It is suggested that, although SAD appears to have a biological basis, that it is also associated with the typical psychological factors that a non-seasonal depression is associated with (ex. negative automatic thoughts, a negative attribution style); therefore, the time-limited traditional treatment interventions, such as cognitive behavioral therapy (CBT) could also be an effective treatment modality for SAD (Rohen et al. 2007).

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Counselor Self-Care

By Emily Bond

In the counseling profession, self-care is a phrase that is often thrown around. As counselors, we make our living by helping others with their struggles. This can be incredibly rewarding and fulfilling. However, as empathic beings, we must be careful to shield ourselves from the unintended consequences that often result from helping others to process their problems. We must learn to care for ourselves in order to better serve our clients.

Let us start by differentiating between some of the terms often associated with self-care and barriers to counselor wellness as explained by counselor wellness experts:

Burnout: the "slow degradation of a counselor's ability to empathize with clients over time" (Shallcross, 2011, n.p.).

Vicarious traumatization: "The symptoms of vicarious traumatization, or secondary traumatic stress, are much the same as those associated with post-traumatic stress disorder… Counselors can acquire vicarious traumatization in as little as one interaction when they are affected by the trauma they hear about through clients" (Shallcross, 2011, n.p.).

Compassion fatigue: "an experience in which exposure to the suffering of clients, coupled with an inability to rescue them from this suffering, results in feelings of depletion, anxiety, depression, resentment and/or emotional withdrawal… Counselors experiencing compassion fatigue may deny clients' traumatic experiences, over-diagnose and pathologize clients, and become increasingly less attuned and empathic" (Shallcross, 2011, n.p.).

Impairment: "occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client" (Shallcross, 2011, n.p.).

It is imperative as counselors and counselors-in-training that we take care of ourselves in order to have the necessary vigor to help others, specifically our clients (Shallcross, 2011). As professional counselors, empathy is offered often, but there is no requirement to have empathy supplied in return. The content of the stories heard on a daily basis can be heartrending. We open ourselves up to connect with clients, but it is necessary at the same time to keep a strong sense of self (Shallcross, 2011).

Balance is crucial, and so are outlets for spiritual, mental, and/or physical recuperation (Shallcross, 2011). In order to find balance, we need to understand the risk and watch for signs of stress and other negative emotions/effects that can come with the territory in this profession. When we become aware of these signs, we need to act. It sounds cliché, but this is an instance where we need to "practice what we preach" and make it a habit to check in with ourselves when it comes to the continuum of wellness to impairment.

According to Shallcross (2011), a few symptoms and signs to watch for include irritation, loss of sense of humor, and low energy. In an effort to avoid or alleviate such symptoms, Roysircar (2009) and Shallcross (2011) offer numerous suggestions for self-care, including:

- Eating a healthy diet and regularly exercising
- Meditating
- Deep breathing
- Doing yoga
- Getting massages
- Sharing in leisure activities with others
- Reading
- Singing
- Listening to and/or performing music
- Journaling
- Taking a vacation
- Setting boundaries between work and personal life
- Using to-do lists to prioritize work-related tasks
- Creating a "reminder folder" filled with thank-you notes/successes
- Changing clothes after work/internship to switch gears
- Joining peer support groups
- Receiving counseling
- Seeking clinical supervision

My own personal journey to self-care began years ago when I was attending junior college. I was supposed to take a Spanish class, but not enough people signed up. I only needed one credit to complete my associate degree, so I signed up for a cardio kickboxing class, and I was hooked. I had never really done more than go for a leisurely walk with friends in regards to intentional exercise. Somewhere along the way though, life happened and I stopped exercising. I always knew I should start up again, but never made the effort or commitment. Shortly after signing up for my first semester of graduate school, I decided I needed an outlet for stress. I began doing spin classes twice a week. A seemingly small change in my routine kick-started my intentional self-care activities. I still experience stress, but I am more aware now and I listen to my body for early signs of trouble.

Self-care is, in my opinion, a very personal thing. It is something that I have truly embraced over the last couple of years, especially since starting my graduate program. Like many techniques and strategies, there is no one solution that fits or works for everyone. Just because it may not fit though, does not mean we should not try it on. I would suggest making a list of enjoyable activities, or even just simple things that make you smile, that fit well into your day. If you are up to challenging yourself, maybe list a few things that are outside of your comfort zone. I definitely did not see myself trying a yoga or a Zumba class a year ago. They now make my list of favorite activities. These changes, some of them very small, in my day have made a huge difference in my life, and I am glad to have started some of these habits now before starting my professional career. I am definitely happier, healthier, and less stressed out. As the holiday season approaches, it is a perfect time to try a few intentional self-care and/or stress-relieving techniques and strategies. Happy holidays and happy self-care!

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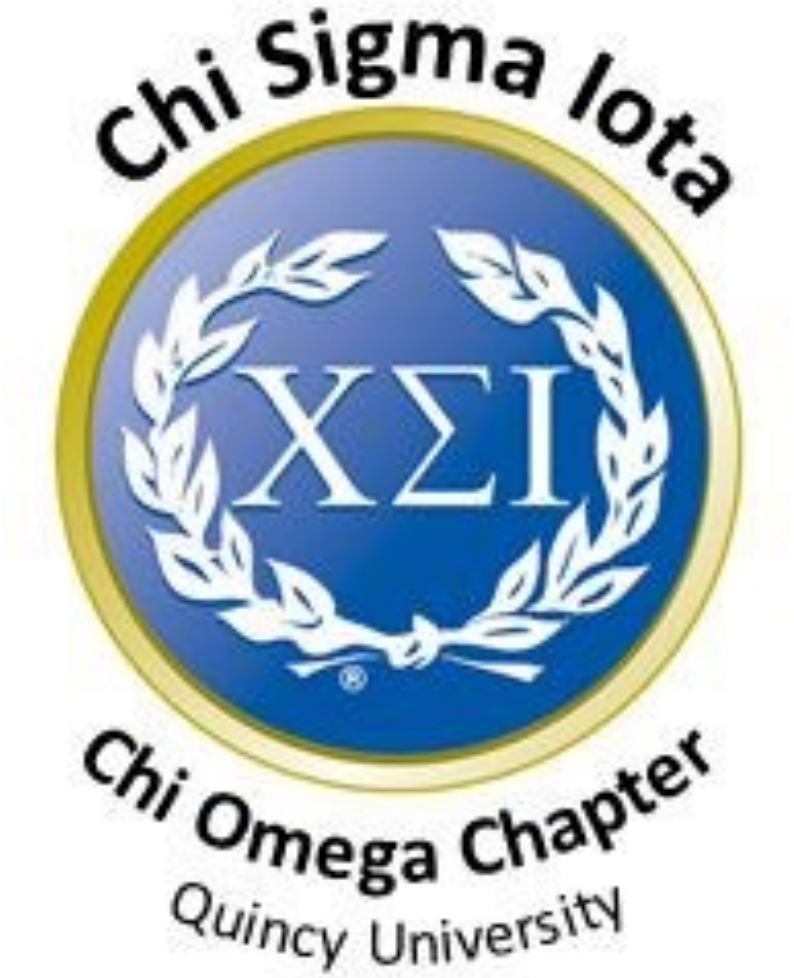

Chi Omega / MEC Calendar of Events—Spring 2015

Combined Executive/General Business Meeting	February 26
Junior Achievement Trivia Night	March 14
Private Practice Panel	April 17
Cap Decorating	May 7
End-of-Year Dinner	May 7
Commencement	May 17