

Too Tired to Sleep

Facilitator's Guide

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Topic: Depression

Abstract:

Clinically depressed patients are three times more likely to utilize medical services than their non-depressed counterparts because of the debilitating nature of depressive symptoms and the increased occurrence of somatic symptoms. Health care providers must learn to recognize a child or adolescent presenting with depressive symptoms and how to screen for depression. This is the story of Chantel, a 17 year-old girl who comes to your clinic with the chief complaint of chronic abdominal pain. During the psychosocial history, you discover a more acute problem, depression and suicidality.

Goal:

To provide learners with a basic understanding of the variety of presentations and general symptoms of depression in adolescents, the basic skills needed to assess depression and suicidality in adolescents, and when an urgent referral to treatment is needed.

Objectives:

By the end of the session, learners will be able to:

1. Formulate a series of questions for the assessment of depression and suicidality and their severity.
2. Describe a plan of action for the depressed or suicidal adolescent.

Prerequisite Cases:

“But All My Friends Do It” (Middle Adolescent Health Screening)
“Amy Goes to College” (Older Adolescent Health Screening)

Related Cases:

“Stephanie’s Long Walk” (Anorexia Nervosa)
“The Crafty Pupil” (Adolescent Substance Abuse)
“The Pain That Just Wouldn’t Go Away” (Recurrent Abdominal Pain)

Themes: Adolescent Health



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Key Words:

Depressive disorder, suicide, risk factors, depression, abdominal pain, adolescent mental health, adolescent health services

Bright Futures Core Concepts:

While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, partnership, advocacy, and prevention/health promotion.

Materials Provided:

- Facilitator's Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1: DSM-IV Criteria for Major Depressive Episode
- Handout #2: Depression in Adolescents
- Handout #3: Suicide Risk Assessment
- Handout #4: Sample Contract for Safety
- Bibliography

Facilitator Preparation:

Facilitators should thoroughly review this guide and the other materials provided.

At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic.

Suggested Format for a One Hour Session:

We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).

Introduction: Depressed mood and suicidal thoughts and behaviors are remarkably prevalent during adolescence. Suicidal ideation in the previous 12 months is reported by 19.3% of high school students on the 1999 YRBS* and suicide attempts by 8.3%. Fortunately, only a small group will complete suicides. However, up to two-thirds of the adult patients who commit suicide have visited a physician in the month prior to killing themselves.¹⁰ Thus, primary care physicians are in a unique position to identify and refer adolescents who may be at high risk for self-endangering behavior. Although depression and suicidality are related, many adolescents report suicidal ideation and attempts in the absence of depressed mood. It is important to assess for both and to determine whether further/emergency psychiatric assessment is needed.

*Facilitators should check the complete 1999 and future YRBS results available from the Center for Disease Control and Prevention web site (www.cdc.gov/nccdphp/dash/yrbs/index.htm).

Open the Discussion: Introduce the case title and the session goal. Explain that this will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

Part I

Chantel is a 17 year old woman who comes to your office with a chief complaint of abdominal pain. She is an obese woman, staring down at the floor, talking quietly. She reports a three month history of mild diffuse abdominal pain. She denies vomiting, diarrhea or constipation, vaginal discharge or dysuria. She has no history of sexually transmitted diseases. She reports normal menstrual cycles with mild dysmenorrhea; her last menstrual period was 2 weeks prior to her visit. She is not currently sexually active but discloses tearfully to you that she was raped 2 months ago by an ex-boyfriend. She currently has no contact with him and does not feel in danger. She has been postponing this visit because she is anxious about having a pelvic exam.

She describes increased fatigue and difficulty sleeping. She also tells you that she does not like school as much as she used to and that her grades are dropping. When you ask about her friends, she tells you that she does not have any close friends anymore. She is not involved in any social or recreational activities and cannot remember why she stopped hanging out with her friends.

Following this reading, ask all participants “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is facilitation of the discussion rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions. Present material from the discussion guide only when needed to complement or redirect the group discussion.

Guiding Questions for Discussion:

What else would you like to know about Chantel? Clinicians should take a complete psychosocial history. Suggest using the HEADSS format (Home, Education, Activities, Drugs, Sex, Suicide/Emotional health) which can be found in the Bright Futures Late Adolescent Screening case, “*Amy Goes to College,*” to elicit this information. Ask residents for suggestions about how these questions might be asked.

Questions from *Bright Futures Developmental Surveillance and School Performance* that assess emotional health include:

- What do you do for fun?
- What are some of the things that worry you? Make you sad? Make you angry? What do you do about these things? Who do you talk to about them?
- Do you ever have bad dreams? How often?
- Do you often feel sad or alone at a party?
- Have you ever thought about running away? Leaving home?
- Do you know if any of your friends or relatives have tried to hurt or kill themselves?
- Do you ever feel really down and depressed?
- Have you ever thought about hurting yourself or killing yourself?

What are the key portions of Chantel's presentation that make you suspicious of emotional distress?

Factors suggesting distress include:

- | | |
|---|------------------------------|
| a) history of sexual trauma | f) school failure |
| b) tearfulness | g) increasing isolation |
| c) lack of eye contact | h) anxiety about pelvic exam |
| d) sleep disturbance | i) history of chronic pain |
| e) anhedonia (e.g., lack of pleasure in school) | |

How would you assess Chantel for Major Depression? Explain that it is always better to start with open-ended questions and then get increasingly specific.

Distribute Handout #1: DSM IV Criteria for Major Depressive Episode and allow learners a few minutes to review the contents. Write the four headings below (Depressed mood, Anhedonia, etc.) on a flip chart or blackboard and ask participants to come up with specific questions that assess that area.

Assessing DSM criteria for a Major Depressive Episode:

Depressed Mood:

You have clearly had a very upsetting thing happen to you? How has your mood been in general lately? (Wait for answer, then ask directly. Follow this format for each question-group below.)

Do you feel like you're depressed?

How much of each day do you feel depressed? How long have you felt that depressed?

Do you think you are more depressed in the winter than the summer, or only in one season?

When you get sad or down, how long does it last?

Have you felt some personal losses recently?

How do you feel about (specific event/life in general)?

Anhedonia:

Do you ever not feel depressed?

Is there anything you do that can take your mind off being depressed?

What do you do to enjoy yourself/have a good time/for fun?

Has your interest in this/these things changed?

Are you able to enjoy any of the things you used to enjoy?

Neurovegetative Symptoms:

How is your appetite? Is this different than usual?

How have you been sleeping? When do you have difficulty?

When you can't fall asleep, what is keeping you awake?

Is it that you just can't sleep, or is your mind racing/having upsetting thoughts?

Do you wake in the middle of the night other than to go to the bathroom, and then can't get back to sleep?

Do you wake up early and then can't fall asleep again?

How is your energy level?

Is it hard to get going/hard to sit still? Do you feel more restless than usual?

How is your thinking?

Can you concentrate as usual?

Is it hard for you to focus things you used to be able to, like watching TV, reading a book or magazine?

Has your interest in food increased or decreased?

Have you gained or lost weight?

Feelings of Guilt or Worthlessness:

How have you been feeling about yourself lately? Are you feeling like you've done something wrong/like everything you do is bad/your fault?

Are you hard on yourself? Are there times when you call yourself names?

Have you been harder on yourself lately?

Shame, humiliation, and self-blame are central experiences/symptoms of survivors of sexual assault (and sexual abuse). Therefore, *how* questions are asked will be critical. It will be important to empathize with the degree of trauma experienced by Chantel and to avoid questions which may be experienced by Chantel as blaming the victim.

It will also be important to observe Chantel's behavior and affect as you interact with her. What is her response to questioning about depression and suicidal thoughts? She may breakdown or decompensate. She may become belligerent or silly. She may avoid questions by changing the subject or not responding. She may appear to dissociate (e.g., to answer questions without affect). These responses reflect Chantel's "coping style" and can indicate that she is becoming overwhelmed. It will be important to be responsive to maladaptive coping and to cease discussion if Chantel's mental status appears too fragile.

Finally, assessment of psychotic features will also be necessary. Are they mood congruent? That is, if Chantel is exhibiting psychotic features, such as hearing voices, are the things these voices are saying consistent/congruent with a depressed mood (e.g., "*you are bad, you should die*"), or are they incongruent with depressed mood (e.g., grandiose messages such as, "*God has a message for you to share with the human race*").

After the group has generated questions in each area, distribute Handout #2: Depression in Adolescents, for learners to use as future reference.

Does Chantel meet criteria for Major Depressive Episode (DSM-IV)? Review the DSM-IV criteria and decision rules for a Major Depressive Episode. Explain that 1) Chantel must meet criteria for depressed mood **or** anhedonia (criteria 1 and 2, respectively), **and** experience any other 4 of the remaining 7 symptoms listed within the same 2-week period; and 2) irritable mood can substitute for depressed mood *in the case of children and adolescents*. You may also wish to explain that a Major Depressive Episode is not necessarily the same as a "Major Depressive Disorder," which is diagnosed on the basis of one or more major depressive episodes, but NO experience of any manic, mixed, or hypomanic episodes. Chantel denies any kind of manic episode.

How would you assess Chantel for risk of suicide? Suicidal ideation and/or intent is a symptom of depression. However, once acknowledged it is important to get an impression of the frequency and seriousness of the ideation, as these are related to likelihood of actual attempt. Also, the presence of intent, seriousness of intent, and access to methods of carrying out intent are critical issues related to risk attempt and potential suicide completion. Finally, remember that predictors of future attempts include 1) a previous suicide attempt, 2) concurrent presence of depression, and 3) experience of suicide of friend or relative.

Many people fear that asking questions about suicidal thoughts will “put ideas in someone’s head” and perhaps precipitate behaviors that would have otherwise not occurred. Although adolescents are influenced by peers who commit suicide, there are no data suggesting that assessment of suicide by a health or mental health provider is “suggestive” in this way. The balance of risk/benefit is such that it is essential for clinicians to assess.

Suicide:

- *Do you ever have thoughts of hurting yourself in any way?*
- *Do you ever think about killing yourself?*
- *What do you think about when you think about hurting/killing yourself?*
- *How often do you think about these things?*
- *Do you think you might ever do any of these things?*
- *Is it possible that you might actually harm yourself or kill yourself?*
- *Do you have a plan?*
- *When you think about hurting yourself or killing yourself, how do you imagine you would do it?*
- *Do you think you might really do this?*
- *Are you able to get the things to enact this plan (e.g., pills, knives, guns)?*
- *What do you think it would be like if you were able to kill yourself? What would it mean to be dead (assess realistic thinking about death)?*
- *Have you ever tried to hurt yourself or kill yourself before?*
- *Have you ever known or heard of anyone who killed themselves?*
- *How close were you to this person?*

Distribute Handout #3: Suicide Risk Assessment, and allow learners a few moments to review its contents.

What other factors may impact on Chantel’s situation? The clinician needs to assess stressful events and sources of support, past psychiatric history, family psychiatric history, and comorbid conditions.

A. Stress and support.

Chantel has already disclosed the most likely precipitant for current distress (ie., a sexual assault); however, it is important to get a sense of other areas of stress and support in her life, as these can potentiate current stressful events or provide a buffer.

Support includes people (e.g. family and friends), institutions (e.g., school, clubs), and activities which make her feel good about herself (e.g., good academic functioning, sports, extracurricular activities).

B. Psychiatric history (Patient and Family)

Past psychiatric history is important. Depression is a recurrent and sometimes chronic disorder, and if Chantel has a history of depression, she is at greater risk for current depression. If Chantel has a history of treatment for depression, this will provide information regarding the level of intervention that has been necessary in the past (e.g. hospitalization vs. outpatient psychotherapy), what has worked, and past treatment providers. In addition, depression runs in families, and it is more likely to occur in children and youth with family histories of other psychopathology as well.

C. Comorbid conditions.

Comorbidity of psychological problems and psychiatric diagnoses is common in adolescents. Comorbidity often indicates a more serious disturbance, with more adverse course and outcomes, including increased risk for suicide. It is important to assess for potential comorbid psychiatric or behavior problems that may be amenable to further assessment and treatment. Remember that symptoms related to psychiatric diagnosis, even if diagnostic criteria are not met, are relevant and predict increased risk for diagnosis, decreased general functioning, and adverse outcomes in the short and long term. In this case, Post Traumatic Stress Disorder (PTSD) is the most salient comorbid condition, both for the increased risk for serious disturbance and suicidality, and its relevance to treatment choices, and psychiatric needs. Other possible comorbid conditions are Conduct Disorder and substance-related disorders. Criteria for these disorders can be found in DSM-IV.

Possible questions to ask Chantel in order to assess for PTSD include:

- *How often do you find yourself thinking about the assault?*
- *Are you able to stop thinking about it if you want?*
- *Does it feel like the thoughts just come into your mind unexpectedly and you can't do anything about it (intrusive thoughts)?*
- *Does it ever feel like the whole thing is happening again in the present even though it's not (flashbacks)?*
- *Are you having any nightmares? (This may have been assessed when you asked about sleep disturbance.)*

You may decide that it is best not to ask questions about conduct disorder at present as they change the focus and may be experienced by Chantel as unempathic and blaming in the context of her disclosure. Often it is best to gather this information from another informant (e.g., parent, friend, teacher).

Should you decide to assess, possible assessment questions include:

- *How do you get along with the adults in your life?*
- *What do you think they would say if I asked them the same question?*
- *Do you get in trouble in school? Do you cut school? Have you ever been suspended? Arrested by the police? Do you get into fights?*

Be sure to get a sense of whether these behavior problems began before age 10 years or later, as there is some evidence that adolescent-onset conduct problems differ etiologically and prognostically from earlier onset conduct problems.

Assessment for substance-related disorders is discussed in the related case, "*The Crafty Pupil*."

Distribute Part II of the case and have participant(s) read it aloud.

Part II

Further questioning reveals that Chantel lives in a group home. Her parents "disappeared" 2 years ago. She is in the 11th grade. She has a history of alcohol abuse but has been sober since living in the group home. She smokes 1-3 cigarettes a day.

When asked about her mood, she states, "*it isn't anything*." She cannot name anything she has done lately that she has enjoyed. She reports feeling too tired to go out with her friends. She also says she feels like no one likes her because she is "*stupid and can't do anything right*." She says she lays in bed for hours trying to fall asleep and wakes up early because she cannot stop thinking about "*things*." When you ask her what "*things*," she reports feelings of guilt about what happened (i.e., the sexual assault, the disappearance of her parents), and that it is her fault. She also reports no appetite lately and that others tell her she looks like she is losing weight. She did not want to talk specifically about her plans but stated, "*if worse came to worse, I would try to cut my wrists just like one of the other girls in my house did a few months ago*."

What are you most concerned about now? What is her level of risk for self-destructive behavior/suicide? Strong suicidal intent and presence of a plan indicate serious risk. Risk is also increased because Chantel knows someone or knows of someone who has attempted or committed suicide.

What is your plan of action? It is most important to decide whether referral for emergency psychiatric evaluation or referral for outpatient therapy is most appropriate, and whether immediate referral for possible admission is needed. Hospitalization can be stigmatizing and should be avoided if it is possible to devise an outpatient plan. Crucial to this decision is the determination of whether Chantel can keep herself safe and contract for safety. Primary care clinicians should be knowledgeable about contracts but should work in collaboration/consultation with mental health clinicians to decide an appropriate management plan.

****Optional Exercise on Safety Contracts: What might be important to include in a contract for safety?** The written or verbal contracts for safety have been found useful by some mental health clinicians. Written contracts are preferred to verbal contracts, unless the risk is assessed as very low (e.g. low intent/no plan). Emphasize that the more specific the contract is, the better. An explicit, concrete plan for what Chantel will do if she should feel unsafe in any way should be included in the *written* contract.

Distribute Handout #4: Sample Contract for Safety, and allow learners a few minutes to review the contents.

If Chantel is able to contract for safety, contact should be made with an adult who will be responsible for supervision and agrees to be available for Chantel any time she is feeling at risk. The contract should be shared with the adult. All should sign, and copies should be made. If there is not an adult available to provide this degree of supervision and support, then immediate psychiatric assessment, and possible hospitalization, is warranted.

Assure the presence of a supportive adult who is willing to take responsibility for supervision, and transportation to the emergency room, if needed.

Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.

Epilogue

Chantel is unable to contract for safety and is escorted to the emergency room for immediate psychiatric consultation. She is admitted to a psychiatric inpatient facility. She was diagnosed with major depressive disorder and PTSD. She remained an inpatient for one week and was started on an antidepressant. On follow-up, her mood was remarkably improved and she was no longer suicidal.

What are your responsibilities for Chantel now? Facilitate a discussion about the primary care physician's follow-up role in managing psychopharmacology therapy or arranging outpatient therapy. Discuss why adolescents might be more or less likely than children or adults to present to a medical office with emotional issues, rather than to a parent or counselor (e.g., developmental needs for autonomy from adults; peer pressure to be cool; stigma associated with mental health services in conjunction with acute social pressure during adolescence; inability to recognize emotional issues when they arise and their relationship to somatic symptoms). Chantel is presenting to a medical clinic with a medical complaint, but this complaint appears to be perhaps more related to critical emotional/psychological issues. The physician is therefore her link to the services she needs.

What may be difficult for medical providers in dealing with issues of depression and suicidality in a medical setting? Discuss how learners felt while hearing about this case. How do you feel when confronted with a 17 year-old girl who has been raped, may be suicidal, and is in your primary care office at the moment? You may want to share that the clinician who actually saw this case described it as "overwhelming." Psychiatric issues may be uncomfortable/unsettling and clinicians must be aware of personal discomfort and the possibility of avoidance as a result (e.g., choosing to focus on medical issues with which you are probably more comfortable). In general, if it is making you anxious, it is worthy of attention.

What are some community prevention strategies?

Primary prevention efforts have included restricting access to methods used to commit suicide, school-based programs, educating health care providers to recognize potentially at-risk teens, and programs that target youth in high-risk groups. Reducing the availability of lethal means (e.g., restrictive gun control laws, regulation of the number of potentially lethal pills dispensed per prescription) has been shown to reduce suicide rates.

School-based programs tend to be directed at a general school population, and thus, may not be effective in changing the attitudes of at-risk youth.

Secondary prevention programs include hotlines, crisis center, and peer support groups (i.e., Ala-Non or Ala-teen) that tend to target suicidal youth.

Refer back to group’s learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Independent Learning/Prevention Exercises: Facilitators may wish to assign “Independent Learning/Prevention Exercises” to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Depression, as well as other avenues of pertinent interest that can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Invite the state Adolescent Health Coordinator to discuss public health approaches to suicide prevention.
2. Visit a school and interview a school counselor about identification and services for depressed teens.
3. Find out about National Depression Screening Day (Screening for Mental Health: 781-239-0071).
4. Schedule a journal club to review evidence based literature on the association of firearms and suicide.
5. Learn about mental health coverage in insurance programs and what parent/patients need to do to access services.

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Part I

Chantel is a 17 year old woman who comes to your office with a chief complaint of abdominal pain. She is an obese woman, staring down at the floor, talking quietly. She reports a three month history of mild diffuse abdominal pain. She denies vomiting, diarrhea or constipation, vaginal discharge or dysuria. She has no history of sexually transmitted diseases. She reports normal menstrual cycles with mild dysmenorrhea; her last menstrual period was 2 weeks prior to her visit. She is not currently sexually active but discloses tearfully to you that she was raped 2 months ago by an ex-boyfriend. She currently has no contact with him and does not feel in danger. She has been postponing this visit because she is anxious about having a pelvic exam.

She describes increased fatigue and difficulty sleeping. She also tells you that she does not like school as much as she used to and that her grades are dropping. When you ask about her friends, she tells you that she does not have any close friends anymore. She is not involved in any social or recreational activities and cannot remember why she stopped hanging out with her friends.

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Part II

Further questioning reveals that Chantel lives in a group home. Her parents “disappeared” 2 years ago. She is in the 11th grade. She has a history of alcohol abuse but has been sober since living in the group home. She smokes 1-3 cigarettes a day.

When asked about her mood, she states, “*it isn’t anything.*” She cannot name anything she has done lately that she has enjoyed. She reports feeling too tired to go out with her friends. She also says she feels like no one likes her because she is “*stupid and can’t do anything right.*” She says she lays in bed for hours trying to fall asleep and wakes up early because she cannot stop thinking about “*things.*” When you ask her what “*things,*” she reports feelings of guilt about what happened (i.e., the sexual assault, the disappearance of her parents), and that it is her fault. She also reports no appetite lately and that others tell her she looks like she is losing weight. She did not want to talk specifically about her plans but stated, “*if worse came to worse, I would try to cut my wrists just like one of the other girls in my house did a few months ago.*”

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Epilogue

Chantel is unable to contract for safety and is escorted to the emergency room for immediate psychiatric consultation. She is admitted to a psychiatric inpatient facility. She was diagnosed with major depressive disorder and PTSD. She remained an inpatient for one week and was started on an antidepressant. On follow-up, her mood was remarkably improved and she was no longer suicidal.

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Handout #1: Criteria for Major Depressive Episode

DSM-IV criteria:

- A. Five or more symptoms present during the same two week period and represent a change from previous functioning.

At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure. Do not include symptoms that are due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) Depressed mood most of the day, almost every day, as indicated by either subjective report (e.g. feels sad) or observation made by others (e.g. appears tearful). **Note:** Irritable mood can substitute for depressed mood in children and adolescents.
- (2) Noticeably diminished interest or pleasure in all, or almost all, activities most of the day, almost every day, as indicated by either subjective account or observation made by others.

Plus at least four of the seven remaining symptoms below:

- (3) Significant weight loss (when not dieting) or weight gain constituting a change of more than 5% of body weight in a month. Or a decrease or increase in appetite almost every day.
- (4) Insomnia or hypersomnia
- (5) Psychomotor agitation or retardation nearly every day observable by others
- (6) Fatigue or loss of energy
- (7) Feelings of worthlessness or excessive/inappropriate guilt
- (8) Diminished ability to think or concentrate, or indecisiveness, almost every day as reported either by subjective account or as observed by others.
- (9) Recurrent thoughts of death, suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- B. The symptoms do not meet criteria for a mixed episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.
- E. The symptoms are not accounted for by bereavement, they persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psycho-motor retardation.

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Handout #2: Depression in Adolescents

- Prevalence rates of major depression reported in adolescents are 0.4% to 8.3%. Life time prevalence is 15-20%.
- Depression is associated with suicidal ideation and attempts.

Questions to Assess Depression in Adolescents:

Depressed Mood:

You have clearly had a very upsetting thing happen to you? How has your mood been in general lately? (Wait for answer, then ask directly. Follow this format for each question-group below.)

Do you feel like you're depressed?

How much of each day do you feel depressed? How long have you felt that depressed?

Do you think you are more depressed in the winter than the summer, or only in one season?

When you get sad or down, how long does it last?

Have you felt some personal losses recently?

How do you feel about (specific event/life in general)?

Anhedonia:

Do you ever not feel depressed?

Is there anything you do that can take your mind off being depressed?

What do you do to enjoy yourself/have a good time/for fun?

Has your interest in this/these things changed?

Are you able to enjoy any of the things you used to enjoy?

Neurovegetative Symptoms:

How is your appetite? Is this different than usual?

How have you been sleeping? When do you have difficulty?

When you can't fall asleep, what is keeping you awake?

Is it that you just can't sleep, or is your mind racing/having upsetting thoughts?

Do you wake in the middle of the night other than to go to the bathroom, and then can't get back to sleep?

Do you wake up early and then can't fall asleep again?

How is your energy level?

Is it hard to get going/hard to sit still? Do you feel more restless than usual?

How is your thinking?

Can you concentrate as usual?

Is it hard for you to focus things you used to be able to, like watching TV, reading a book or magazine?

Has your interest in food increased or decreased?

Have you gained or lost weight?

Feelings of Guilt or Worthlessness:

How have you been feeling about yourself lately? Are you feeling like you've done something wrong/like everything you do is bad/your fault?

Are you hard on yourself? Are there times when you call yourself names?

Have you been harder on yourself lately?

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Handout #3: Suicide Risk Assessment

Suicidal Ideation

- Suicide is 3rd leading cause of death among 15-24 year olds: 15 deaths/100,000 males and 3.3 deaths/100,000 females
- 19.3% of high school students report having suicidal ideation in past 12 months (1999 Youth Risk Behavior Survey)
- Rates of suicidal ideation are much higher among youth with lifetime history or current diagnosis of Major Depression; however, youth without a history of Major Depression may also report suicidal ideation
- Rates of suicidal ideation are higher among depressed than anxious youth
- Rates of suicidal ideation are higher among girls than boys

Suicide Attempts

- 8.3% of high school students (1999 YRBS) had attempted suicide one or more times during the 12 months preceding the survey
- Intensity and frequency of ideation predicts attempts
- Intensity of ideation predicts lethality of attempt
- Rates of attempts are higher in gay/lesbian/bisexual youth
- Rates of attempts are higher among girls than boys
- Rates of completion are higher among boys than girls (boys tend to use more violent and lethal means, e.g., firearms, hanging)

Predictors of Suicide Attempt

- Previous attempt
- A plan
- Depression
- Suicide attempt by friend or family member
- Unwillingness to use outside resources/lack of perceived support
- History of substance use disorder
- Low social self-competence
- Low social support from friends
- Hopelessness
- Functional impairment due to illness/injury
- Gay/lesbian/bisexual sexual orientation
- Availability of weapons
- Preoccupation with death

Questions:

- *Do you ever have thoughts of hurting yourself in any way?*
- *Do you ever think about killing yourself?*
- *What do you think about when you think about hurting/killing yourself?*
- *How often do you think about these things?*
- *Do you think you might ever do any of these things?*
- *Is it possible that you might actually harm yourself or kill yourself?*
- *Do you have a plan?*
- *When you think about hurting yourself or killing yourself, how do you imagine you would do it?*
- *Do you think you might really do this?*
- *Are you able to get the things to enact this plan (e.g., pills, knives, guns)?*
- *What do you think it would be like if you were able to kill yourself? What would it mean to be dead (assess realistic thinking about death)?*
- *Have you ever tried to hurt yourself or kill yourself before?*
- *Have you ever known or heard of anyone who killed themselves?*
- *How close were you to this person?*

Too Tired to Sleep
Handout #4: Sample Contract for Safety

I, (name of patient), promise not to do anything to harm myself in any way. If I have thoughts about harming myself I will talk to (identified adult) about it, and I will agree to do what she/he says I should do about these thoughts.

If I feel unsafe in anyway, or I think I might actually do anything to harm or kill myself, I will 1) talk with (identified adult) about it and, 2) call (identified clinician). If (identified adult) is not available, I promise to call (identified clinician).

Telephone number to call: (telephone # of identified clinician)

Signature of patient

Signature of identified adult

Signature of clinician

I, (name of identified adult), promise to keep (name of patient) safe in the most appropriate manner possible. This includes being available to speak with (name of patient) if he/she is feeling unsafe or thinks he/she will cause harm to him/herself in any way.

Signature of identified adult

Too Tired to Sleep

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Suggested Readings (Annotated):

American Psychiatric Association. *Diagnostic and Statistical Manual - Fourth Edition*. Washington, D.C: American Psychiatric Association, 1994.

Lists current psychiatric diagnoses and criteria for diagnosis. Provides discussion of differential diagnoses and associated features for each diagnosis.

Lewinsohn PM, Rohde P, Seely JR. Adolescent suicidal ideation and attempts: Prevalence, risk factors, and clinical implications. *Clinical Psychology—Science and Practice* 1996;3:35-46.

Epidemiological data for suicide ideation and attempts among a high school sample. Discusses risk factors which differentially predict depression, suicidal ideation and attempts respectively.

Woods ER, Lin YG, Middleman A, Beckford P, Chase L, DuRant RH. The associations of suicide attempts in adolescents. *Pediatrics* 1997;99:791-796.

Assessment of risk factors which collectively predict suicidal ideation and attempts among a community sample of adolescents.

Educational Resources on the World Wide Web:

American Academy of Child and Adolescent Psychiatry-Facts for Families. This site provides access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The information sheet entitled "The Depressed Child" is #4.

<http://www.aacap.org/publications/factsfam/index.htm>