CE 2.5 contact hours

BY MAUREEN KRONING WITH KAYLA KRONING

Teen Depression and Suicide

A SILENT CRISIS

ABSTRACT: *Adolescent depression is a serious problem affecting 10.7% of all teens and 29.9% of high school students; 17% of high school students have contemplated suicide. Yet, depression in teens is often unrecognized. This article relays the tragic death of a 17-year-old, along with symptoms of depression and suicide in adolescents; DSM-5 criteria for depression; treatments including protective factors, psychotherapy, and medications; and imparts interventions for addressing this huge but silent crisis.*

KEY WORDS: *adolescents, depression, DSM-5, mental health, nursing, suicide, teens*

Most of us have observed sadness in teenagers. We may think their melancholy is due to hormone imbalances, moodiness, or teenage rebellion. But teen depression is a life-threatening concern. My daughter, Kayla, watched her 17-year-old best friend struggle with depression and eventually commit suicide. Feelings of loss, frustration, guilt, and unanswered questions continue to haunt Kayla. She wishes she could have helped her friend, said something that made a difference, or somehow answered his calls for help. She regrets not being able to change that horrible morning when she received the news of her best friend's suicide (see Sidebar: My Best Friend).

The reality is, adolescent depression is a serious problem. The 2001–2004 National Comorbidity Survey-Adolescent Supplement of 10,123 adolescents found that 11% of teens suffer with major depressive disorder by age 18 (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015). More recently, the U.S. National Institute of Mental Health (NIMH, n.d., a) found that 2.7 million adolescents ages 12 to 17 (10.7% of all adolescents) suffered a major depressive episode in 2013. If depression is left untreated, the intense feelings of sadness, hopelessness, anger, or frustration can last for weeks, months, or years. The World Health Organization (WHO, 2015) reports that worldwide, over 350 million people suffer from depression, making it the leading cause of disability and contributor to the overall global burden of disease. It is critical to recognize symptoms of depression to make early treatment possible and prevent pain, suffering, and possible death.

2.7 million ADOLESCENTS SUFFERED A MAJOR DEPRESSIVE EPISODE **in 2013.**

Our goal in sharing this tragic story of the death of a 17-year-old is to highlight the vital need to speak up early to parents and professionals when a teen displays signs of depression. Suicide is the second leading cause of death for 15 to 24 years old (Suicide Awareness Voices of Education [SAVE], 2015a). Learning from our personal experience may help save the life of someone suffering with depression and considering suicide. Our words and actions can help end the silent crisis of teen depression.

SIGNS OF DEPRESSION

At some point, most of us have, or will experience sadness. However, sadness is usually short-lived. When a person suffers with depression, it can affect work, school, eating, and the ability to enjoy life over an extended period. It is imperative to make the distinction between sadness and clinical depression; when depression is recognized, needed treatment can be obtained.

Depression can affect one's ability to do the simplest things, such as waking up in the morning, brushing your teeth, going to school or work, and eating a meal. Depressed feelings make it hard to function normally, focus, and participate in once-enjoyable activities. Depressed feelings result in little to no motivation or energy, making it hard to get through each day.

Symptoms of depression range from feeling sad, empty, hopeless, angry, cranky, or frustrated; to weight loss or gain; to thinking about dying and/or having suicidal thoughts. A more exhaustive list of depressive symptoms is provided in Table 1. In addition to recognizing symptoms of depression, it is important to acknowledge that each person experiences depression in his own way. Even though someone may not have all the classic symptoms of depression, he or she may still be clinically depressed.

What causes depression? Heredity plays a significant role, accounting for half of the etiology behind depression. Depressed individuals often are direct family members of others who suffer from depression. Depressed individuals may not have the same thoughts as healthy persons, due to neurotransmitter imbalances in the brain. Specifically, depressed individuals experience abnormal regulation of cholinergic, catecholaminergic (noradrenergic or

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TABLE 1
SIGNS AND SYMPTOMS OF A MAJOR DEPRESSIVE DISORDER (MAJOR DEPRESSION)

Qualifier:	Signs & Symptoms:*
A. Must have at least five symptoms over at least a two-week period, where one symptom has to be either depressed mood or loss of interest or pleasure in activities, almost every day, most of the day, and nearly every day:	1. Depressed mood indicated by depressed person or report of others. Characterized by sadness, emptiness, hopelessness, irritability, or restlessness.
	2. Markedly diminished interest or pleasure in all or almost all activities.
	3. Significant weight loss when not dieting, or weight gain.
	4. Inability to sleep, or oversleeping.
	5. Psychomotor agitation or retardation.
	6. Fatigue or loss of energy.
	7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional).
	8. Diminished ability to think or concentrate, or indecisiveness.
	9. Recurrent thoughts of death, recurrent suicidal ideation, with or without a specific plan, or a suicide attempt.
B. Symptoms cause clinically significant distress or impairment in:	Social functioning (i.e., isolates, unable to attend regular social engagements).
	Occupational functioning (i.e., poor work performance, failure to go to work).
	Physical functioning (i.e., feels "bad," aches, pains, headaches, cramps, digestive problems; symptoms do not ease with treatment).
	Other important area of functioning.
C. Depressive episode is *not* due to:	Effects of a substance (i.e., alcohol, amphetamines, barbiturates, corticosteroids, some β-blockers, interferon).
	Effects of a medical condition (i.e., brain tumor, cancer, thyroid disorder, stroke, AIDS, Parkinson's, multiple sclerosis, adrenal gland disorder).
D. Occurrence is not better explained by another mental disorder:	(i.e., schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders).
E. There has never been:	A manic episode.
	A hypomanic episode.

*Depressed feelings of grief/bereavement typically are tied to a sad event and are not accompanied by pervasive feelings of worthlessness and self-loathing.
Sources: American Psychiatric Association, 2013; Coryell, 2015; National Institute of Mental Health, n.d., b.

dopaminergic), and serotonergic (5-hydroxytryptamine) neurotransmission (Coryell, 2015). The neurotransmitter imbalances can prevent someone from recognizing that he or she could find help. Many depressed individuals cannot imagine being happy again. They feel unbearable emotional, and sometimes physical, pain that seems to have only two options: dying or living with pain (SAVE, 2015b). Neuroendocrine dysregulation may relate to problems of the hypothalamic-pituitary-adrenal, hypothalamic-pituitary-thyroid, or growth hormone systems, areas that can be treated (Coryell).

Psychosocial factors also play a role in depression. Major life stressors can precipitate depression but normally do not cause clinical depression, except in people predisposed to depression. Once someone has been clinically depressed, she is at higher risk for depression. Women are at higher risk, possibly related to heightened response to daily stressors (emotional sensitivity), higher levels of monoamine oxidase enzyme responsible for degrading neurotransmitters, higher rates of thyroid dysfunction, and the endocrine changes of menstruation and at menopause (Coryell, 2015).

THE NATIONAL SUICIDE PREVENTION Lifeline, 1-800-273-TALK (8255), CAN PUT A PERSON IN TOUCH WITH HELP.

Depression can be categorized as mild, moderate, or severe (WHO, 2015). The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), released by the American Psychiatric Association (2013), classifies eight depressive disorders (Table 2). Five of the depressive disorders are classified according to symptoms. *Major depressive disorder* is defined as a period lasting two weeks or longer, when a person experiences at least five of nine symptoms as listed in Table 2, where one symptom is depressed mood or loss of interest or pleasure in activities. *Persistent depressive disorder* is a depressed mood that lasts for at least two years in adults, but only one year in children or adolescents. *Other specified or unspecified depressive disorders* involve

symptoms that do not meet the full criteria for another depressive disorder, but cause clinically significant distress or impairment. *Disruptive mood dysregulation disorder,* diagnosed in children, involves severe emotional outbursts and irritable mood. The remaining three depressive disorders are classified by etiology and include *premenstrual dysphoric disorder, depressive disorder due to another medical condition,* and *substance/medication-induced depressive disorder.* Adolescents can have any of these disorders.

ADOLESCENT DEPRESSION

In the past, people believed children could not suffer with depression. When teens showed signs of depression, it could be mistaken for the moodiness of puberty. Research today reveals that teens may be clinically depressed (NIMH, n.d., a).

How prevalent is depression among adolescents? Data from the 2013 national Youth Risk Behavior Surveillance Survey (YRBSS) showed that 29.9% or three out of 10 U.S. high school students expressed feeling sad or hopeless almost daily for two or more weeks (Centers for Disease Control and Prevention [CDC], 2015). Data also revealed that adolescent females feel sad or hopeless, seriously consider attempting suicide, and attempt suicide at almost twice the rate of males (Table 3). Furthermore, Hispanic teens report feeling sad or hopeless, seriously consider attempting suicide, make a suicide plan, and attempt suicide more than Black or White teens (Table 3). The ongoing YRBSS results give strong evidence that depression and suicidal thinking are fairly common among youth.

Clinical depression may lead to attempts at self-harm. The YRBSS survey revealed that 17% of high school students in the U.S. expressed having contemplated committing suicide, 13.6% made a suicide plan, and 8% reported attempting to commit suicide at least one or more times in the 12 months before the survey. Table 3 lists the prevalence of male, female, and race of high school students who contemplated committing suicide, made a suicide plan, and attempted suicide over one year. The CDC (2015) also reports that 157,000 young people between ages 10 and 24 years were seen in Emergency Departments in 2013 for self-inflicted injuries. These self-inflicted injuries are a cry for help.

Teenagers may show indicators of depression that are different from adults. Depressed teens may sulk, act out, get in trouble at school, express negativity, and feel misunderstood by others. One study suggests that as many as six students in a classroom may be struggling with depression at any given

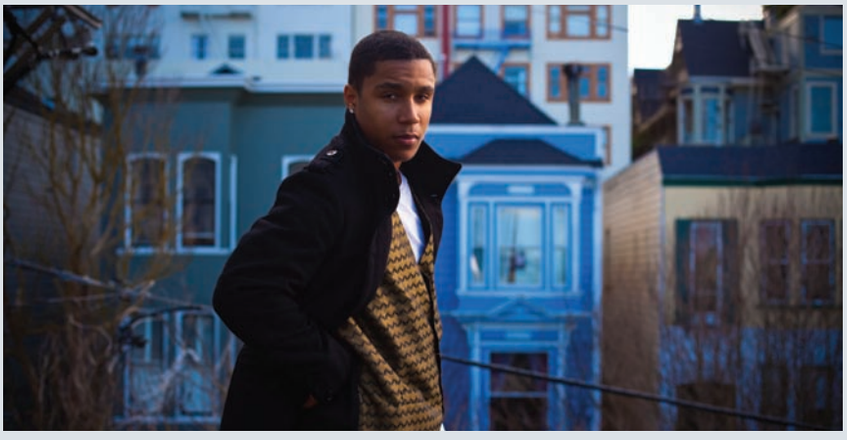

TABLE 2: DEPRESSIVE DISORDERS IN THE DSM-5

Disorder:	Characteristics:
Disruptive mood dysregulation disorder	Diagnosed between 6 and 18 with onset before age 10. Involves severe, recurrent temper outbursts ≥ three times weekly for ≥1 year; and persistently irritable mood.
Major depressive disorder, single and recurrent episodes (MDD)	Experiences ≥ five symptoms over ≥2 weeks; with depressed mood or loss of interest/pleasure in activities. Symptoms: a) cause clinically significant distress or impairment; b) are not due to a substance or medical condition; and c) are not better explained by another mental disorder.
Persistent depressive disorder (PDD) (dysthymia)	Depressed mood occurs for most of the day, more days than not, for ≥2 years in adults and 1 year in children/adolescents; symptom-free intervals last ≤2 months. MDD may proceed or occur during PDD.
Premenstrual dysphoric disorder	Similar to premenstrual syndrome but symptoms (i.e., mood swings, depressed, anger/conflicts, fatigue, sleep, and physical problems) occur in most menstrual cycles, are greater, more severe, and interfere with functioning; affects 5–10% of women.
Substance/medication-induced depressive disorder	Depressive symptoms caused by use of drugs. Diagnosis based on clinical criteria.
Depressive disorder due to another medical condition	Depressive symptoms caused by physical disorders. Ruled out by clinical evaluation and testing (e.g., CBC (complete blood count); electrolyte, TSH (thyroid stimulating hormone), B12, and folate levels).
Other specified depressive disorder	Symptoms do not meet the full criteria for another depressive disorder but cause clinically significant distress/impairment. Includes recurrent periods of dysphoria with ≥ four other depressive symptoms that last <2 weeks, and depressive periods that last longer but include insufficient symptoms for another depressive disorder.
Unspecified depressive disorder	

Sources: American Psychiatric Association, 2013; Coryell, 2015; National Institute of Mental Health, n.d., a.

TABLE 3: NATIONAL YOUTH RISK BEHAVIOR SURVEY 2013: PERCENTAGES OF HIGH SCHOOL STUDENTS WHO FELT SAD/HOPELESS AND HAD SUICIDALITY, BY GENDER* AND ETHNICITY

	FELT SAD OR HOPELESS‡	Seriously Considered Attempting Suicide	Made a Plan About How They Would Attempt Suicide^	Attempted Suicide§
Total (both sexes, all races)	29.9	17.0	13.6	8.0
Total males	20.8	11.6	10.3	5.4
White males	19.1	11.4	10.1	4.2
Black males	18.8	10.2	7.7	6.8
Hispanic males	25.4	11.5	11.2	6.9
Total females	39.1	22.4	16.9	10.6
White females	35.7	21.1	15.6	8.5
Black females	35.8	18.6	13.1	10.7
Hispanic females	47.8	26.0	20.1	15.6

*Total females > males; Total Hispanic > Black; Total Hispanic > White (based on t-test analysis, $p < 0.05$) for all four responses
‡Almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey
^Total White > Black (based on *t*-test analysis, $p < 0.05$)
§Total Black > White (based on *t*-test analysis, $p < 0.05$)
Source: CDC, 2015.

TABLE 4: MEDICATIONS USED TO TREAT DEPRESSION*

Pharmacologic Class:	Mechanism of Action:	Medication Examples:	Comments:*
Selective serotonin reuptake inhibitors (SSRIs)	Prevent reuptake of serotonin 5-hydroxytryptamine (5-HT) resulting in more 5-HT to stimulate postsynaptic 5-HT receptors.	citalopram (Celexa) escitalopram (Lexapro) fluoxetine (Prozac) fluvoxamine (Luvox) paroxetine (Paxil) sertraline (Zoloft) vilazodone (Viibryd)	Side effects related to SSRI include stimulation of: 5-HT1 receptors—antidepressant, anxiolytic effects 5-HT2 receptors—anxiety, insomnia, sexual dysfunction 5-HT3 receptors—nausea, headache
Serotonin modulators (5-HT$_2$ blockers)	Block 5-HT2 receptors and inhibit reuptake of 5-HT and norepinephrine	trazodone (Oleptro) mirtazapine (Remeron)	Trazodone most often given at bedtime due to sedative effect; may cause orthostatic hypotension.
Serotonin-norepinephrine reuptake inhibitors	5-HT and norepinephrine mechanisms of action	desvenlafaxine (Pristiq) duloxetine (Cymbalta)	
Norepinephrine-dopamine reuptake inhibitors	Mechanism of action unknown; influence catecholaminergic, dopaminergic, and noradrenergic function	bupropion (Wellbutrin)	Can help with attention deficit/hyperactivity disorder. Can cause hypertension and seizures in some patients, especially at higher doses.
Heterocyclic antidepressants (tricyclics)	Increase availability of norepinephrine and serotonin by blocking reuptake. Long-term use regulates α 1-adrenergic receptors	amitriptyline (Elavil) imipramine (Tofranil) nortriptyline (Pamelor) desipramine (Norpramin) clomipramine (Anafranil)	Not used as often because of anticholinergic properties, toxicity in overdose, plus other antidepressants have less adverse effects.

*Some patients become more depressed, agitated, or anxious 1 week after starting or increasing SSRI dose. Adolescents should be watched closely and treated for increasing depression, agitation, and suicidality.

time (Huberty, 2012). Teens struggle with school, grades, family, friends, and their identity. Bullying is a serious problem, contributing to teen depression. In 2013, 19.6% of U.S. high school students reported being bullied on school property, whereas 14.8% reported bullying electronically by email, chat rooms, instant messaging, websites, or texting (CDC, 2015). Sadly, family members, friends, and school personnel may not notice teens who are sad, lonely, and distressed, as they can be invisible or try not to be noticed.

Many depressed adolescents are not properly diagnosed. Some mistakenly look at depressed teens as being difficult or blame the teen for feeling the way they do. Alternatively, depressed teens may appear mentally healthy, forcing a smile so others will not worry. However, eventually the signs of depression will become evident. It can be difficult to tell whether adolescents with behavior changes are going through a temporary

phase or are suffering from depression (NIMH, n.d., a).

TEEN SUICIDE

The first step to preventing teen suicide is recognizing and treating depression. Effective, early intervention will help reduce the burden and disability of depression. A combination of proactive support, mood elevating medications, and psychotherapy such as Cognitive Behavioral Therapy, can effectively treat teen depression (TADS Team, 2009). The earlier treatment is started, the better the response to treatment. Table 4 lists medications used in treating depression.

Critical protective factors for suicide include support from families, friends, and others, such as the school or faith community (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Faith-based organizations, such as Young Life (2015), a Christian organization, provide teenagers with adult leaders who provide time, energy, and guidance to direct teenagers on the "path to fulfilling lives." Specific protective factors against adolescent suicidal behavior, many of which can be influenced, include self-esteem, self-discovery, defense mechanisms, productive coping strategies (i.e., focusing on the positive), spirituality and religion, reasons for living, caring by family and other adults, parental involvement, family connectedness, school and neighborhood safety, and pharmacotherapy (Rasic, Kisely, & Langille, 2011).

Depressed teens need to be assessed for how they respond to life, especially stressful situations. Negative thinking patterns and behaviors can be replaced with effective coping strategies, such as good problem solving, helping with motivation to change, building self-esteem, resolving relationship problems, and learning stress management techniques. If chronic pain is a variable, management of pain is important. Other studies additionally support the importance of religion and increased frequency of attendance at religious services as protective factors for depression and suicidal ideation in adolescents (Langille, Asbridge, Kisely, & Rasic, 2012; Rasic et al., 2011). According to the NIMH (n.d., a), helping teens recognize that they are not alone, that there are people who want to help them, and that depression is a real, treatable brain illness can help teens receive the care they need.

Adults and peers can help prevent suicide by knowing the risk factors, warning signs, and asking if a teen has been thinking about suicide. SAVE (2015c) states it is okay to ask, "Do you ever feel so badly that you think about suicide?" "Do you have a plan to commit suicide or take your life?" "Have you thought about when you would do it (today, tomorrow, next week)?" "Have you thought about what method you would use?" The more specific thinking and plans a person has made, the more serious the risk of suicide. Risk also is greater if warning signs are new and/or have increased, or are possibly related to an anticipated or actual painful event, loss, or

My Best Friend

BY KAYLA KRONING

Many love stories start with the words, *There was this boy….* But this story is different. There was this boy, who was my best friend, and I was his. That love was not enough for him to keep living and fighting through the depression he endured. My best friend took his life at age 17. This is a hard story to tell, but it is important to share with others, to be screamed across bridges, shared with friends over hot tea, and through streaming tears. I hope that by sharing my story, I can raise awareness of depression and suicide. Through open discussion and education, I hope young people will begin to receive the help they deserve, that kind of help my best friend deserved.

My story isn't so different from many teens. I often wonder why teenage depression and suicide are so prevalent in our nation. The answer lies, in part, in the large amount of stress teens experience daily. Teens stress about many things, such as doing well in high school, gaining peer acceptance, and attending college. Teens are focusing on these things while, simultaneously, searching for how they fit in the world. However, depression is not a mere consequence of social behaviors, but also a result of neurochemical imbalances. Hopefully, through time and effort, scientists can pinpoint the cause of this terrible disease and discover a cure. Until then, we must focus on raising awareness of this disease, so depressed individuals' struggles do not go unnoticed.

Sadly, despite the shocking statistics on depression, many believe depressed teens are just going through a phase of sadness and will grow out of it. A phase is something that is not a part of a person; it is independent of one's character, and it is as easy to end as it is to start. One does not simply *end* depression. The depressed individual typically fights feelings of depression until he either gets the help he deserves or dies without it.

"I WAS ill equipped TO HELP A YOUNG MAN who was dying FROM SOMETHING I DID NOT understand."

My friend's depression was the result of the reasons previously mentioned, and maybe more of which I was unaware. He did reach out for help through counselors, family, and friends. Unfortunately, we did not understand or recognize just how bad his depression was. We also did not know how to help alleviate the pain he was in, to help him feel hope and some happiness, or to want to go on living. The debilitating effects of my friend's depression did not receive the recognition they deserved. Many people who knew my friend tried to equate his depression to sadness, maybe even demeaning the severity of the depression by dismissing his mood as just being difficult, moody, and a normal part of being a teenager.

Adults do not need to feel responsible to cure a teen's depression, but should feel responsible to act in simple ways, by

first recognizing the signs and symptoms. There is the need to acknowledge teens who are depressed, to talk to them, to convey a message of care. Teens need to know someone notices them and, more importantly, wants to find a way to help them. If enough people start doing this, the stressors in school, home, or social environments may become more bearable.

I tried to help my best friend, to be there for him, to listen to his inner most feelings. When I noticed his depression was getting worse, I reached out to our closest friends at school and, together, we tried to help him. I invited my friend to a Christian youth group at the church I attended. He never shared his struggle with depression at this group but, perhaps, if I had invited him much earlier, he might have opened up and received the help he needed.

The weekend my best friend told me of his plan to commit suicide, I talked to him for hours, trying to make sense of the words that were being thrown at me. He told me his plan, although very real, was just an option, one he was not really planning on taking. He told me he needed the comfort of knowing there was an out to his struggle. This, he repeatedly let me know, did not mean he was going to take the out. The remainder of the countless hours I spent talking to him were to convince him to choose the other path–life.

I worked to give him a reason to live. To be honest, I wanted the reason to be me. I wanted him to live *for me*. I can acknowledge now how wrong my approach was; one cannot live for another person alone. You must live for (excuse my sappiness)—sunsets, Netflix, popcorn binges with close friends, the idea of one day seeing a little child with your eyes or nose, hot tea, and a warm stomach; feelings within a whole spectrum, and so much more. Even so, I was young and ill-equipped to help a young man who was dying from something I did not understand. That did not stop me from trying. I tried so hard. In fact, my mom noticed my physical and emotional exhaustion and prompted me to open up to her. I told her everything, and being a nurse, she knew the next step was to contact his parents and let them know what their son was feeling. She contacted my high school next, notifying the school counselors regarding what was happening. Even I, in my distraught state, contacted his old psychiatrist, hoping he knew what to do. My mom and I did this in an effort to provide my friend with the help he not only needed, but he deserved.

Unfortunately, our efforts proved futile. My friend had a plan, and, like any plan, when it is set in motion, it resembles a snow ball gaining speed down a huge hill, increasingly becoming more unstoppable. We were too late, and now he is gone. Because of this, I urge you to spread awareness of this debilitating disease, before a nearly unstoppable plan is set in motion, and it, once again, becomes too late.

change (Youth Suicide Warning Signs, n.d.). Warning signs of suicide are listed in Table 5.

Is there a test that can help predict whether a depressed teen may attempt suicide? Simon et al. (2013) found that adolescent responses to question 9 on *The Patient Health Questionnaire, version 9* (PHQ-9), a multiple-choice, 10-item, self-report inventory, used as a screening and diagnostic tool for mental health in primary care settings, was a strong predictor of subsequent suicide attempts or death. Question 9 asks, "Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself?" Respondents choose from not at all, several days, more than half the days, and nearly every day (SAMHSA, 2013). It is important if signs of suicide are recognized that help is obtained immediately. Parents and school authorities need to be notified and treatment sought. The National Suicide Prevention Lifeline, 1-800-273-TALK (8255), can put a person in touch with a local crisis center and help.

NEED FOR ACTION

Major depression and suicide can be averted if society takes action by careful consideration of the individual's developmental level, identifying high-risk groups, and researching the best evidenced-based interventions to reach the largest numbers (Muñoz, Beardslee, & Leykin, 2012; SAMHSA, 2012). However, despite the prevalence of depression, the impact on school performance, and lifelong costs, there is little discussion about intervention for depression among school personnel.

TABLE 5: WARNING SIGNS OF SUICIDE

- Talking about wanting to die or to kill oneself.*
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.*
- Displaying severe/overwhelming emotional pain or distress; talking about feeling trapped or in unbearable pain.*
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Anger or hostility that seems out of character or out of context.
- Sleeping too little or too much.
- Withdrawn or feeling isolated; change in social connections/situations.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.
- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things previously cared about.
- Visiting or calling people to say goodbye.
- Making arrangements; setting one's affairs in order.
- Giving things away, such as prized possessions.

*Key warning signs in youth.

Sources: Suicide Awareness Voices of Education, 2015c; Youth Suicide Warning Signs, n.d.

Sadly, it is common for someone suffering with depression to go unnoticed. Teen depression continues to be a quiet crisis in schools. To intervene, we need raised awareness of the problem, trained school personnel, and structures for delivering mental health services in schools (Desrochers & Houck, 2013). Schools with health centers and readily available mental health services for students report decreased teen depression and suicide ideation and improved mental health outcomes (Solimanpour, Geierstanger, McCarter, & Brindis, 2011).

A comprehensive, coordinated national strategy to prevent suicide will go a long way in stopping this quiet crisis. In 2010, approximately 200 public and private organizations created the *National Action Alliance for Suicide Prevention* (NAASP, 2015a), whose goal is to eliminate the tragic occurrence of suicide. In 2012, the Alliance released a comprehensive National Strategy for Suicide Prevention that outlines ways to increase public dialogue and support. These include countering shame, prejudice, and silence; addressing the needs of vulnerable groups; coordinating efforts to address behavioral health; promoting system and policy changes to support suicide prevention; bringing public health and behavioral health together; reducing access to lethal means among those with suicide risks; and utilizing the most up-to-date knowledge for suicide prevention (NAASP, 2015b).

Recognizing the power of social networking, the Action Alliance collaborated with SAMHSA and Facebook to prevent suicide by connecting those contemplating suicide with trained professionals. Facebook allows users to report suicidal comments they may see posted by a friend, using the Report Suicidal Content link or report links found throughout Facebook. Facebook will then immediately send an email to the person who made the suicidal comment, who is then encouraged to call the National Suicide Prevention Lifeline (1-800-273-TALK) or click the link provided to talk with a crisis worker (Newswise, 2011).

NURSING INTERVENTION

As the nation's largest group of healthcare providers, nurses are in a unique position to make an impact on teen depression and suicide. Nurses are trained in assessment and can provide support and education to patients, families, the public, and schools to promote protective mechanisms for depression, as well as recognize depression. School nurses have great opportunity to advocate for, and ensure, strict policies that address crisis intervention for evaluation and treatment, provide education about teen depression and suicide, confer with teachers and counselors, and support students and parents. Faith community nurses can influence faith and community settings, along with public and community health nurses. Nurses in any setting interact with adolescents and families, and can actively screen and offer help.

Acknowledge THE TEEN WHO IS DEPRESSED...**convey care** FOR THE TEEN.

Adolescents and their friends or family may be worried or embarrassed about the idea of having a mental disorder. Yet many open up to nurses. Nurses can explain that depression is a serious disorder, caused by physiologic imbalances, and requires specific treatment just like diabetes or hypertension. They can encourage individuals, that with treatment, the prognosis for depression is good. Nurses can educate about treatments, medications, and side effects. All should be reassured that depression does not reflect a character flaw. Telling adolescents and parents that the path to recovery is rocky can help put feelings of hopelessness in perspective, as well as improve adherence to prescribed treatments.

Web Resources

- Action Alliance—http://actionallianceforsuicideprevention.org
- SAVE—http://www.save.org
- Communicating about Teen Suicide—http://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/suicideyouth.html
- Warning Signs—http://www.youthsuicidewarningsigns.org

If you encounter an adolescent or anyone who raises concern, Youth Suicide Warning Signs (n.d.) suggests the following steps:

1. Ask if he or she is okay or having thoughts of suicide;
2. Express your concern about what you are observing in his or her behavior;
3. Listen attentively and nonjudgmentally;
4. Reflect what is shared and let the person know he or she has been heard;
5. Tell the person he or she is not alone;
6. Let him or her know treatments are available that can help;
7. Guide the person to additional professional help.

CONCLUSION

Depression is a quiet crisis, but it need not be. Increased awareness, with the development of needed mental health programs, can reach teens who need help. Working with social media can reach teens who may be suffering in silence. Collaboration with teen support groups and faith organizations can create safe havens for teens. Through a coordinated effort on the part of public and private industry, government agencies, concerned family, friends, schools, and healthcare professionals, we can make a difference in preventing suicide and saving lives.

For a difference to occur, people need to acknowledge the severity of teen depression and the significant risk of suicide. Teens need our attention to make them feel valued, accepted, and secure in the knowledge that people are there to help them. Teens taking

their lives is a tragedy. As a nurse, what might you do to end the silent crisis and save the lives of teens suffering with depression?

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