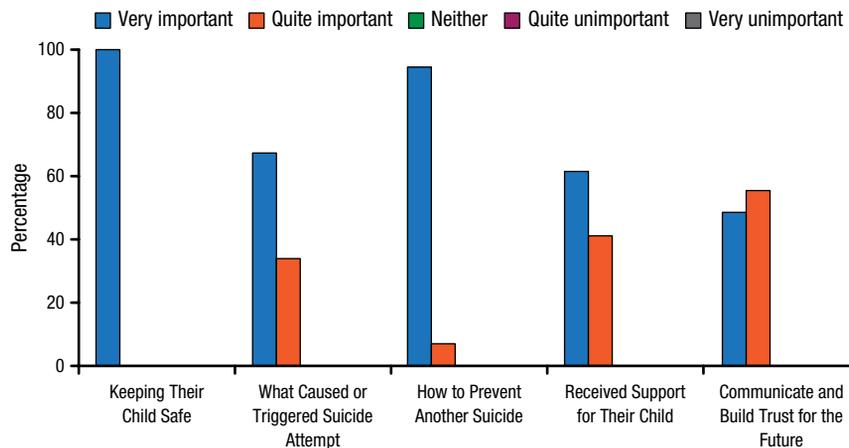


Figure 1. What Matters Most for Parents Whose Child Has Made a Nonlethal Suicide Attempt?



"Neither," "quite unimportant," and "very unimportant": 0% across factors.
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generation was used to survey an interdisciplinary panel of experts on adolescent mental health about the pertinent family, community, and societal factors involved in attempted youth suicide. The process consisted of 2 rounds of surveys given to the expert panel. Panelists chosen for the study were employed in the adolescent mental health unit at Midwestern Behavioral Health Hospital. They included social workers, clinical therapists, nurses, psychologists, and psychiatrists. A total of 31 experts were surveyed in round 1, and 16 were surveyed in round 2.

The experts were asked the following 5 questions designed to uncover issues most important to parents of children who attempt suicide: What matters most for parents whose child has made a nonlethal suicide attempt? What are the needs of parents whose child has made a nonlethal suicide attempt? What are current treatment interventions for parents whose child has made a nonlethal suicide attempt? What is the best method to recruit parents into a study examining their experiences after a child's suicide attempt? The last item asked experts what other fields of experts in adolescent suicide prevention to include in a larger Delphi study.

Each question had 3 to 6 answers, which the experts were asked to rate as "very important," "quite important," "neither," "quite unimportant," and "very unimportant." The results for the first question are shown in Figure 1.

The presenters concluded that an advanced understanding of the parents' experience has implications for creating acceptable and useful interventions and communication strategies aimed at preventing youth suicide.

Exercise Increases Self-Efficacy and Improves Depression

Written by Rita Buckley

Exercise therapy improves both mental and physical health in patients with major depression. Although several characteristics of the disease (eg, loss of interest or lack of pleasure) interfere with participation, motivational strategies incorporated into exercise interventions can promote adherence [Knapen J et al. *Disabil Rehabil.* 2014].

Kirk Bergmark, APN, PMHCNS-BC, Palos Medical Group, Palos Heights, Illinois, USA, addressed how exercise can be successfully integrated into the treatment plans of patients with depression using evidence-based recommendations and connections with health and fitness facilities.

Mr Bergmark reports that exercise increases levels of the same neurotransmitters targeted by antidepressants: norepinephrine, dopamine, and serotonin. Optimal levels of norepinephrine stimulate a sense of well-being. Dopamine is associated with the reward system of the brain, and serotonin is associated with regulating mood, appetite, and sleep.

Improved transmission of dopamine and norepinephrine together strengthens compliance with prescribed physical activity in patients with depression and residual fatigue [Stenman E, Lilja A. *Med Hypotheses.* 2013]. Exercise may also benefit the brain by enhancing neural plasticity [Silverman MN, Deuster PA. *Interface Focus.*



2014] and expression of growth factors, such as the brain-derived neurotrophic factor [Phillips C et al. *Front Cell Neurosci.* 2014].

A substantial body of evidence supports the value of exercise in the treatment of people with depression [Stanton R, Happell BM. *Issues Ment Health Nurs.* 2013]. Mr Bergmark's prescription calls for 45 minutes to 1 hour of aerobic activity (eg, walking, running, swimming, or cycling) for a minimum of 3 to 5 days a week. Intensity should be low to moderate to start, with an increase to a moderate level over time.

Collaborative arrangements with a health and fitness center willing to support prescription recommendations and provide incentives (eg, a free 1-week pass) and follow-up (eg, ongoing assessment) can help patients start exercising. Use of evidence-based counseling can promote behavior change and adherence.

Motivational interviewing, a form of collaborative conversation in which clinicians elicit and explore a patient's own reasons for change, is an empirically supported counseling style that strengthens a patient's own motivation and resolve [Zuckoff A. *Surg Obes Relat Dis.* 2012]. Rather than telling patients what to do and how to do it, clinicians invite them to share the doubts, reasons, and concerns that make them uncertain that they are ready to change. By understanding and accepting those reasons, they can then ask patients to explain why they might want to change, the potential benefits as they see them, and how adherence would be consistent with what they care about or value most.

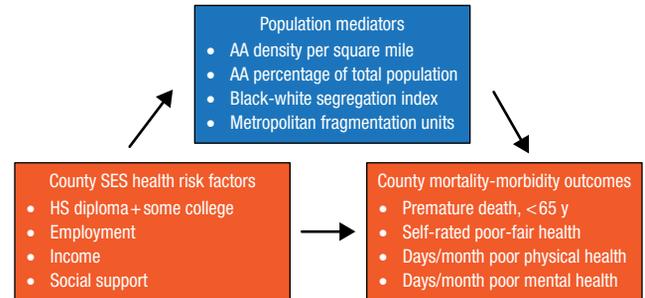
In the context of motivational interviewing, it becomes possible to elicit a commitment to change, which, in turn, predicts new behavior [Amrhein PC et al. *J Consult Clin Psychol.* 2003]. Ultimately, the decision to exercise despite depression is a byproduct of a clinician-patient partnership, a relationship based on trust. It is an alliance that encourages and supports a patient's choice to adopt a lifestyle that serves his or her own best interests.

African American Population Percentage Negatively Mediates SES Association With Poor Mental Health

Written by Toni Rizzo

Social inequities are strongly associated with health disparities. Research shows that chronic and traumatic social inequities can be epigenetic and complicate the health risks of inflammatory illnesses such as type 2

Figure 1. Social-Ecological Model of African American Population: Effects on SES and Health



AA, African American; HS, high school; SES, socioeconomic status.

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diabetes, cardiovascular disease, and depression. Linda D. Oakley, PhD, University of Wisconsin, Madison, Wisconsin, USA, presented the findings of this study, conducted with Rick P. Voland, PhD, University of Wisconsin, Madison, Wisconsin, USA which tested basic assumptions of the epigenetic biological link between social inequities and health disparities in African Americans living in the United States.

The study design was guided by an upstream social-ecological model of race as a potential mediator of the relationship between social inequities and health disparities (Figure 1).

The study sample was collected from US population data aggregated by county [University of Wisconsin Population Health Institute. 2014 County Health Rankings. 2014]. The mediators tested were African American total population, density, and percentage; level of black-white population segregation; and nonracial fragmentation of municipal infrastructures. Socioeconomic status (SES) was defined as the percentage of county adults who had a high school diploma with or without some years of college, were unemployed, lacked support, and had children living in poverty. Health outcome variables were premature mortality, fair or poor health, number of days of poor physical health, and number of days of poor mental health. Premature mortality was defined as mean years of life lost before age 65. Fair-poor health was defined as mean adult self-ratings of fair or poor health. A poor physical health day was defined as mean days lost in the past month due to poor physical health. A poor mental health day was defined as mean days lost in the past month due to poor mental health.

The total county population was 233584 (11.1%) African Americans, with a mean African American density per square mile of 4993. The mean number of premature