Suicide and the Community Psychiatrist

Did you happen to forget that it was our nation's 39th Annual Suicide Prevention Week, September 8-14? Well, I did, and expect many community psychiatrists did, given the lack of list-serve chat talk about what to do approaching that week.

I found out myself in an unexpected but most meaningful way that might be of interest to my fellow community psychiatrists, whether you are Jewish or not. In the middle of the recent Jewish High Holy Days, the Rabbi at our reform synagogue asked me if I would serve on a study session planned on Yom Kippur. Yom Kippur is a day to pray to be put in "The Book of Life" for next year. It was to be September 14th, the same day as the last day of suicide prevention week. Tragically, those who commit suicide do not want to be put into that book, which should evoke concern on the part of any community.

I agreed to participate, thinking this would be quite easy. As a community psychiatrist and administrator for over 40 years, I knew much about suicide, didn't I? And, hadn't I spoken to the public on many occasions? Just to be sure, I asked colleagues for their recommendations. Soon, I realized there would be more of a challenge ahead than I realized, but at least I thought I would be more prepared.

Here's what happened and how I used what I learned from other community psychiatrists. In a religious sense, I found the entire process to be almost "miraculous".

I decided to focus my part of the presentation on my own professional direct experiences with suicide. Why? One reason is that I did not have any family suicide to talk about personally. Therefore, if I wanted to model about the necessity of talking more publicly about this stigmatizing topic, I had to share something personal. That something personal was the two suicides in my career.

I still felt pretty confident as I stepped up to talk to the audience of about 200 people. I began to tell them about one of my first patients in my first year of residency when I was learning how to be a psychiatrist. He was an elderly man who came in somewhat reluctantly for depression related to job loss and a loveless marriage. After the first session, I began an older antidepressant and made plans to add some psychotherapy. At the second visit, he seemed a bit better.

It was just then during the presentation that I started to tear up and sob. And sob. I looked to my wife, secretly hoping she might come up to comfort me, but at the same time too embarrassed to ask her to do so. Then, a man on the aisle near the front softly said toward me: "take your time, relax". And I did. And I was able to go on to say that the patient's wife called a few days later to say that he had walked into Lake Michigan and drowned, an apparent suicide.

At that time, 40 years ago, I had panicked and I told the audience that. What would my supervisors say? Was I not cut out to be a psychiatrist? Most fortunately, they were kind, gentle, supportive, and educational, all the things that would help anyone reacting to a suicide. They told me I probably wasn't taught yet that a transition to apparently doing better could be a high risk time, when the patient had the energy and resolve to end their life. That is one reason why people were often surprised by a suicide. They said I would learn from this and be a better psychiatrist. I never did have another patient to commit suicide.

Still retaining my composure, I went on to the second suicide. This time, 15 years later, it was a staff member. I had been the Medical Director of a large community mental health center. One of the staff was whispered to have AIDS. When he didn't come to work for 3 days, we started to be concerned. Maybe he was in a hospital. Confidentiality about AIDS at that time was a big concern. Just to be sure, a staff member and I decided to go to his house. There we found him on the bed, dead, with a gunshot wound to the head. After some days, we processed this with our grieving staff. I think I had some of what is called suicide grief, that grief complicated by a combination of guilt, anger, shock, relief, and intermittent intrusion of traumatic memories. Maybe, I told the audience, given my sobbing, some of that grief was still with me.

As a staff, we realized that maybe we were taking suicide assessment in too routine away. Perhaps, too, we weren't paying enough attention to our own mental health. After all, psychiatrists and mental health professionals were thought to have high rates of suicide. We soon did much continuing education on suicide and also became closer as a staff.

I went on to tell the audience that we now know how to prevent most suicides, provided that the person comes to treatment in a comprehensive system using the best practices. They were reassured. How did I know that? First, from Mark Ragins, M.D. of The Village in Long Beach. He had reminded us of the importance of the therapeutic alliance in preventing suicide and to be very cautious about rushing to hospitalize a suicidal patient. Second was a system and practice that I did not know of before. That was from Karen Chaney, M.D., Medical Director of Adult Services for Magellan Behavioral Health (see www.magellanofaz.com and click on Suicide Prevention). Their goal was to get to "zero" suicides in their system. After canvassing best practices elsewhere, they developed a protocol. Essential seemed to be a brief screening questionnaire. One provider found at least 155 out of 2400 screens were positive for high risk. Here, too, there was no rush to hospitalize, but to pull together all the resources: psychotherapy, medication, home visits, family involvement, and telephone checks, among them. Now, it is crucial to remember that these positive screens were in patients not necessarily thought to be of risk by their caregivers. The conclusion is that most suicides should be thought of as a system failure.

I would probably add that suicides are also a community failure, for we need the public to watch for suicide risk and help get people into good systems of care. In our study session, another presenter talked about a new public education on suicide prevention through the local university. So far, though, I couldn't tell if there were any psychiatrists involved. I offered to be.

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The "miraculous" part to me happened right after the presentation was over. I walked up to the gentleman who had calmed me and thanked him. As I found out, he was the father of a young lady who had committed suicide only two months before. Her suicide was so traumatic to the community that her funeral had an overflow attendance. Now, he, in all his suicide grief, was able to comfort me!? What an example of how the community and community psychiatrists can work together and comfort one another.

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Depression and Danger to Others

Depression is not generally associated with dangerousness to others. In "worst case" situations, however, depression and resultant suicidal thinking/suicide attempts/suicide can be dangerous to others.

The clearest examples of situations where a depressed person is a danger to others are in those instances where a depressed individual kills someone, sometimes followed by suicide. Homicide-suicide is a worldwide problem, although the percentage of homicides accounted for by homicide-suicide varies widely amongst countries. There are several situations where depression precipitates murder, and then sometimes suicide:

- Infanticide and postpartum depression: The murder of a child under one year old by his mother. Fifty percent of infant homicides occur within the first four months, with a prominent form being "altruistic" or murder out of love, i.e., the suicidal parent does not want to leave the child "alone" and acts in what she thinks is the best interest of the child.
- Filicide: The killing of a child by a parent, which accounts for 60% of all child homicides. Depressed women who committed filicide report thinking about their own death and the death of their child(ren) for days or weeks before the event.
- Adolescent parricide, whereby a shamed and humiliated son (usually) kills a parent based on a belief this will result in a "relief of dysphoric feeling."
- Domestic homicide and homicide-suicide perpetrated by members of an older (over 65 years-old) couple include depression as one of the more frequent psychiatric disorders -- a global finding.
- Mass murder followed by suicide is the all-too-common example of extra-familial killing followed by suicide. Depression is the leading diagnosis found in these cases.

There are other ways a parent's suicide is dangerous or damaging to children. Thoughts of harming their infant occur in 41% of depressed mothers (six times the rate compared to non-depressed mothers) and these thoughts lead mothers to withdraw from their infants. Children of women with postpartum depression experience poor physical developmental outcomes.

Children bereaved by parental suicide have more depressive symptoms, disproportionate rates of suicidality and hospitalizations for suicide attempts; more psychiatric referrals, PTSD-like symptoms with guilt and self blame, higher rates of personality disorders, increased rates of convictions for violent crimes, and a substantially greater risk of suicide themselves.

Depression can be a contributing factor in a number of other situations where a suicide causes harm to others. "Suicide epidemics" have been a quagmire since long before organized psychiatry began to try to untangle its nuances. Such epidemics are known to occur sporadically, but repeatedly, in certain populations such as American Indians and in certain sites such as psychiatric inpatient units.

Suicide by car crash is an effective way to disguise a suicide: Driver suicide was ranked in the year 2000 by the WHO/Euro Multicentre Study on Para-suicide as the twelfth most common method of attempted suicide, but there is currently wide variance amongst countries in reported driver suicide. Suicide by motor vehicle is dangerous to others because the driver has no control of the actual outcome.

Some people who are intent on killing themselves set up a scenario to use another person as the lethal agent, and that other person is often a policeman/policewoman, thus "suicide by cop." In such cases, there may well be bullets flying in all directions.

Depression can be a contributing factor to pathological fire setting, and any fire setting is dangerous to the proximate population. Fire setting is frequently used in filicide. Patients with pyromania have a higher number of previous depressive episodes as compared to patients with other impulsive control disorders.

Death by self-immolation in western and developed countries is an uncommon event, and is usually a suicide in a depressed person. In eastern and developing countries, setting oneself on fire is multifactorial, but here tradition often masks suicide rooted in depression. In self-immolation, the fire setter is the sole target, but once the fire is set, the individual who set the fire has no control over the fire's course or its destruction.

Suicidality, secondary to depression, can be a danger to others. People who commit such acts predominantly suffer from mood disorders, and the most prevalent mood disorder is major depression.

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