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YOUTH SUICIDE RISK

Let's Talk About It

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The call came in shortly after 2:00 p.m. on a Wednesday. The father who left the voicemail said he wished to speak to me as soon as possible about his sixteen-year-old daughter who had recently been hospitalized at John Muir Hospital in Concord.

I called him back by the end of the day. He was from Palo Alto and had gotten my name from a Stanford doctor who knew me well from my residency days. Wisely, the father was conducting due diligence about the next best step for his daughter upon discharge from the hospital.

The daughter, whom I shall call Nancy, had been under psychological care in one form or another since age ten. She had been diagnosed with depression and anxiety and took a low dose of Zoloft daily. In the outpatient world, she already had a therapist, a psychiatrist, and an eating disorder specialist. Added to this, she was enrolled twice weekly in a dialectical behavior therapy group.

He asked if she should return to this therapeutic framework, enter a residential treatment program, or begin a partial hospital program (PHP) or intensive outpatient program (IOP). More broadly, the father was desperate to know what all parents in similar painful circumstances want to know: "What do we do?"

A junior in high school, Nancy made excellent grades. Nonetheless, he said, she worried constantly about tests, college applications, and friends. Three days before our call Nancy told her mother that she could not stop thinking about suicide. It had been going on for days. She had visions of cutting her wrists with a box cutter her father kept in the garage for breaking down cardboard for recycling. After this she said something more concerning.

"I've made my peace with death," Nancy apparently said in a depressed manner, her head low, eyes averted.

An hour later the mother and father took her to the emergency department for evaluation and she was admitted. The morning of our phone call a social worker had told the parents she would probably be released within forty-eight hours.

"Have you talked to her about it and told her how you feel?" I asked the father.

"Talked to her about what?" he responded.

"Her death by suicide and how it would affect you."

He was taken aback, even a bit put off, by the nature of my question.

"No, I haven't," he answered.

During that phone call and one more the following day I helped the father to understand the intricacies of psychiatric care and I honestly shared what my personal decision-making process would look like if it were one of my two sons who was hospitalized for similar risk. I educated him about the genetics of depression and grounded him in the science of "gene-environment interactionism," the most accurate model for understanding depressive illnesses and suicide risk.

But what mattered most in our conversations was my specific recommendation that he have an open-hearted, loving conversation about suicide with his daughter. I counseled him to talk about it—directly, earnestly, not avoiding the words "death" and "suicide."

My suggestion was that he take time for contemplation and get in touch with how he would feel if she were gone. He should find a quiet place to sit with a few simple tools—a pen and paper. On them he should write down his thoughts and feelings. He would feel pangs of grief, probably, and that was okay. In one sense that was the point: to express his true feelings about her death, including love, grief, and fear.

I counseled that after free writing he should prune the page of everything extraneous, distilling his flow of sentiments down to a single loving essence. Whenever he felt ready, at a time when his daughter was nearby and he felt soft and tender, even tearful, he should go to her and talk about it.

Talk About It

Between 2005 and 2012 mortality rates declined for all ten leading causes of death in the United States with one exception: suicide. Uniquely, this form of death increased from 10.9 per 100,000 to 12.6 per 100,000. In 2013, the latest year for which national data are available, suicide accounted for 41,149 reported deaths, 11,226 of which were adolescents and young adults aged fifteen to thirty-four years old. In 2013 suicide was the second leading cause of death in youth.[1] Morbidity is another metric by which to measure the impact of suicidal behavior. Each year, according to a 2015 CDC report, approximately 157,000 youth between the ages of ten and twenty-four receive medical care for self-inflicted injuries at emergency departments across the nation.[2]

Over the past year youth suicide has received increased media attention in the United States. Specifically, the Bay Area has been affected by an adolescent suicide cluster in Palo Alto that generated much local coverage. Nationally, the *New York Times* ran a feature article in July of this year entitled "Suicide on Campus and the Pressure of Perfection." In April Frank Bruni in the *Times* penned "Best, Brightest—and Saddest?" about the Palo Alto teenage deaths, most of which occurred on Caltrain tracks. Most recently, in December of 2015, *The Atlantic* released "The Silicon Valley Suicides: Why Are So Many Kids with Bright Prospects Killing Themselves in Palo Alto?" by Hanna Rosin.

Partially by coincidence, partially not, my book, *Suicide Risk in the Bay Area: A Guide for Families, Physicians, Therapists, and Other Professionals*, came out in the midst of this growing local and national attention to a tragic and preventable form of death. My reasons for writing the book were multifaceted, including the loss of my mother by suicide in the 1970's, the loss of a patient by suicide in 2008, and, most assuredly, the unnerving news of an increasing rate of youth suicide both in the Bay Area and the nation.

Most of all, my interest lies in the area of youth suicide prevention.

Nothing is more devastating than the loss of a young life not yet lived. These deaths are fully preventable, and it is my belief that no effort, no energy, and no expense should be spared in studying youth suicide and tackling it from every possible angle in American society, including enhanced medical student, resident, and physician education.

What does the research show? Most prominently, it shows that removal of access to lethal means of suicide—like firearms and medications fatal in overdose—saves lives; substance abuse, comorbid with mood disorders, is deadly; medications, especially lithium and clozapine, can be anti-suicidal; psychotherapy and follow-up care after suicide attempts both independently reduce risk; and physician education in depression recognition and treatment lowers suicide rates.[3]

In my book I underscore another powerful intervention to lower suicide risk: talk about it. My clinical experience, along with growing evidence, bears out the efficacy of this intervention. In particular, a missing link in suicide prevention is training parents and other family members to talk openly and honestly with someone who is at risk of suicide; that is to speaking lovingly and compassionately with the at-risk person about possible death by suicide. I identify an entity called the "suicide complex" that blocks communication about suicide risk at all levels, leaving at-risk individuals isolated, ashamed, and guilt-ridden. As a consequence, their illnesses go underrecognized and undertreated. Research in family therapy in youth suicide risk validates the role of parent-child communication and compassion in reducing repeat attempts in suicidal adolescents between the ages of twelve and seventeen.[4]

Physician Interventions

Physicians are typically trained to screen for suicide risk and, in the event of suicidal ideation or contemplation of a method or plan, to refer the patient or to call for an immediate consult, depending upon acuity. These are validated, critical approaches to suicide risk. But there is more a physician can do. Vitally, you, the doctor, can take out time to talk about it with patients, parents, and other family members.

Imagine you are a primary care doctor seeing Nancy in your office and she acknowledges to you that she is having thoughts of suicide. Let's even imagine she says, "I've made my peace with death." What do you do? The intervention begins with the calm recognition that what the sixteen-year-old needs is to talk about complex and confusing feelings rather than be hurried to the emergency department, perhaps by police. What would benefit Nancy the most is for her doctor to be comfortable hearing her story. Ask gentle, open-ended questions just as you would to obtain any other history. What's going on? When did it start? Has it happened before? What makes it better and worse? What happened recently to bring it on?

Instead of conducting a rapid suicide risk assessment show your caring and curiosity to understand her experience. We all want deeply to be understood by others, and in suicide risk nothing is more essential. Talk and listen primarily to understand and, as part of that meaningful human interaction, determine level of risk. Once you have connected, expressed concrete hope, and assessed risk consider the best plan whether it be follow-up the next day, medication, referral, or immediate psychiatric consultation.

The second intervention is to speak separately with family members and encourage them to talk about it. Family conversations about suicide are challenging, to say the least. But they can be deeply moving and even life saving. Guide family members to speak directly about death by suicide with loved ones and to express their true feelings of grief and lifelong pain in the event of such a loss. Encourage them to listen, empathize, and validate. These three—listening, empathizing, and validating—constitute a matchless triad in talking with someone with suicide risk.

Nancy

Nancy's father contacted me several weeks after our initial two calls. He reached out to let me know that he and his wife had spoken to his daughter about suicide risk. They sat down with Nancy in her bedroom after the writing exercise. The essence they developed, he said, was a commitment do anything for the sake of her health. She could get C's and D's. It didn't matter. She could change schools. She could take a gap year before college. The father told her he would take a leave of absence from his job to be with her. The parents would get their own therapeutic help. The whole family, perhaps, could take a hiatus from the Bay Area and go on a self-fashioned one-year sabbatical.

Stated in another way, the essence Nancy's parents communicated was that nothing was more important to them than Nancy, just as she is, and that nothing would cause them more lifelong hurt and sadness than her death by suicide. They would move mountains to keep her alive. They did not just entertain these thoughts privately. They did not assume she already knew them. They did not affirm their love for her offhandedly on a multitasking busy day.

They took out time. They prepared. They made her the center of their attention and felt their love—and the prospect of her death—in their hearts. Then, in a moment of clarity for them all, they connected at the deepest level with their daughter. The father and mother came to tears. So did Nancy.

"It was wonderful for all of us," he described to me. Nancy's parents reached her emotionally, not intellectually. I believe that we should all—family members, friends, therapists, teachers, pastors, and especially doctors—aim to develop that ability to the fullest extent possible. Talking about suicide is tough. It's not a panacea. However, it is a vital intervention that ignites human connection and hope. It breaks through the "suicide complex" that obstructs identification, treatment, and prevention. Physicians have the opportunity with every patient experiencing suicidal thoughts to talk about it in the office and, whenever possible, to encourage family members to go directly to the heart of the matter and talk about it with loved ones in a deep, emotional, transformative way.

Talk about it. The conversation begins in the doctor's office.

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