Learning from a Suicide

By Courtenay Young

This is an actual case history. For various reasons, despite the client having died, all names and possible identifiers have been changed. Details have been compiled from various sources.

I was employed for a while as a psychological therapist in a Clinical Psychology department that served a rural area of Scotland, once a thriving mining community, now a little like the "Land of Mordor", but twenty years after the fall of the Dark Tower. The mines were closed, the land was green again, but the people were still quite devastated. I worked in local health centres, clinics and GP surgeries, seeing people referred by GPs and also the occasional psychiatric out patient referral.

George was referred by his GP with high levels of anxiety and low mood, and was not sleeping well. He was aged 42 and lived in the family house. He was being prescribed Trazodone, (150 mgs nocte) a tri-cyclic antidepressant with a sedative component. This was of only partial benefit to his anxiety. George presented himself as a mild person, very gentle and calm: he was very likeable. His anxiety was high, but was also quite internal. He did not appear depressed. There were no obvious impairments.

His father had died (age 70) of Alzheimer's three months previously, and George had nursed him through his last three years of illness, giving up work semi-permanently, especially after the company that he worked for went bust. His mother had committed suicide 16 years earlier, throwing herself off a local railway viaduct. George had two elder sisters, both married, with families, and living. He had a reasonable social life with a number of friends. He had had one or two previous episodes of depression.

George was well educated and was also a qualified airplane pilot, flying instructor and mechanic, proud of this achievement but also a little disappointed perhaps that he had never got his commercial license. He had also worked for 10 years for the Inland Revenue; and the business that went bust, started by a friend of his, was in corporate entertainment with quad bikes, paintballs, and hill walking. Whenever his dad was feeling OK, George helped out at a local airfield with their aircraft maintenance and a little bit of flying or instructing. He drank about 2 pints of beer a day and did not smoke. He was single, though he had had two heterosexual relationships of about 4 years duration each.

George described, quite openly, that one of his major worries was that his two sisters were now contesting their father's will. This had been made many years earlier, when his mother was still alive even. George had been left the family house and a third of the monetary estate: the sisters received a third of this monetary estate each; they both had houses of their own. The sisters had recently taken out an injunction that prevented George selling the house and froze the monetary assets. They were also demanding accounts as to how much money George had received from his father over the last three or four years. He had a little independent capital of his own. He stated that he was very worried that he would lose the house, his only home, and all his capital, and would have nowhere to live. He had been out of work for four years and was worried whether, especially given his emotional state, whether he could get back into proper employment again. The anxiety seemed real and appropriate.

I saw him for psychotherapeutic counselling for about 11 sessions, booked over a five monthly period. Through out most of this time period, my caseload in the clinic was such that I could only book appointments at 3 or 4-week intervals. He scored: Beck's Depression Index = 18/63 (borderline/clinical depression); Beck's Anxiety Index =29/63; Life Event Stress Inventory (Holmes & Rähe) =318 [parent's death 100; change in finances =38; caring for parent 80; family legal trouble 80].

In these early sessions, we discussed several stress prevention strategies and I gave him some printed information about anxiety and stress. I also taught him the Autogenic Technique and advised him to try to use it regularly. He reported feeling a bit better by the third session, but had been thrown into a panic attack by a letter from the sister's lawyer.

He described a fear of being out of control and I also became aware of an underlying feeling of impotence or inability to take any positive action. He felt that there was nothing much he could do to help himself.

By the 4th session, the doctor had increased his Trazodone as the panic attacks were becoming of increasing frequency. His anxiety levels increased when he was further away from home and he was becoming scared of being in confined spaces. Despite discussing how to prevent (or control) a panic attack specifically, nothing much seemed to be of help, yet he said he was grateful for the sessions and enthusiastic about the therapeutic contact. I encouraged him to try taking more exercise, walking with the dog, and to try to get back to his former levels of fitness. We also discussed what he might be able to do with the little capital he had available; possibly put a deposit on a smaller house so that at least he ahd something to fall back on, and he was also fitfully doing up one room in the family house to rent out (to a student or something) to ease his financial situation and give him some company. He reported feeling increasingly depressed about his situation, having very little energy, and a lot of nervous tension – waking him up in the night. We also used some specific cognitive techniques: stopping the *"Yes, but ..."* resistances to help and aspects of the depressive thinking spiral, which he said that he did a lot.

By the 7th session, four months into the treatment (medication & counselling), he told me that he was being given an appointment for a psychiatric assessment with a consultant psychiatrist, Dr 'White' in a few weeks. He then asked for some private sessions, so that he could be seen more frequently as the next available clinic appointment was four weeks away. With the agreement of the GP and informing my supervisor, at George's request, I arranged to see him privately, at a centre that I used for my private practice. I saw him three times in this way, before his next health centre appointment. We worked on controlling his panic attacks, using breathing techniques, and he discussed a little more openly the relationship he had had with his mother and his sisters. The family dynamic, as he described it, was not a pretty one, with his mother being quite critical and dominant and his sisters taking their cue from her. His father, apparently, was the only one person seemed to 'accept' him for who he was. He spoke also a little more about his mother's suicide, for the first time, and how it had affected him.

The consultant he saw, Dr White, recommended that he switch from Trazodone (which did not seem to be controlling the anxiety) to Fluoxetine or Prozac (20 mgs p.d.), a more conventional (Selective Serotonin Re-uptake Inhibitor) SSRI anti-anxiety and anti-depressant medication. The psychiatrist also referred him to another unit for an anxiety management group (though this was never taken up as the next available group was scheduled to run in a few months time). He further recommended that George explore possible retraining or employment opportunities, as he was remarkably 'under-diverted' at that time. He was given some literature on anxiety and stress. No further appointment was thought necessary.

I saw him next, in the clinic, about 10 days after this appointment and he had just switched his medication as the letter had come through to the GP from the psychiatrist. He had been worried that the psychiatrist would have recommended him for a hospital admission; and also mentioned that he felt that this might be detrimental to his job prospects, and might also be taken advantage of by his sisters in their legal action. We spoke again about working consciously to "step out from under" what he felt was the life-long domination of his elder sisters. I specifically asked him about suicide and he said that he had thought about it, but had been so affected by his mother's that he thought it extremely unlikely. Our next clinic appointment was for about three weeks later.

Two weeks later, two weeks after he had stopped taking the Trazodone and switched to Prozac, he made an appointment with his GP about his increasing levels of anxiety. He reported considerable levels of anxiety, some depression and suicidal ideation. The GP was deeply concerned and arranged for an immediate appointment with the Psychiatric Emergency Team (PET) and, later that evening, he was seen by a Senior House Officer, Dr 'Reede', and a Psychiatric Staff Nurse. They reported that he was talking about dwelling in the past too much, while withdrawing from social activities. His mood was low, however he seemed to have a satisfactory appetite and sleep pattern (!). He complained of some weight loss (half a stone over two months). He reported that whilst with friends he was able to concentrate and do things normally. He sometimes awoke early and ruminated, which caused him additional distress. He specifically "denied any active self-harm or suicidal thoughts or plans" however he admitted to some ideation "if things got unbearable". He said he was hopeful for the future and denied feeling worthless.

He admitted to panic like symptoms, which continued to distress him associated with palpitations, sweating, trembling and a degree of anticipation. He said that experienced these whilst outside and at home, but with increasing frequency when outside. Apparently they increased in frequency when he found himself dwelling in the past. He was asked about drinking alcohol and admitted to about 2 glasses of wine at night, most days. However that evening he smelt slightly of alcohol and was seen to have a silver flask in his pocket that seemed to contain spirits. On further questioning there was no evidence elicited to confirm any alcohol dependence syndrome or excessive use. A note was made to make a further careful assessment about any excessive alcohol intake.

. He was reported as being rational and coherent in his account. Further to this he appeared well kempt with a friendly humour. His thought content was mainly preoccupations about the situation with his father's will and generated anxiety about the outcome. There was no evidence of any delusional ideation, nor formal thought disorders, nor plans to self-harm. He denied any abnormalities of perception, was cognitively intact, and insightful about his situation. He was amenable, thankful for the input provided and would continue with his medication. Neither of the health professionals he met that evening were convinced that he had any significant depressive illness or underlying psychiatric morbidity that might have warranted a hospital admission. He was advised that Prozac might take 6 weeks to work effectively and a few Diazepam (2 mgs) were prescribed to help cope with sleep and agitation. A "low risk" diagnosis was made. *"He was not suicidal."*

That was on a Tuesday night. A letter from the team was written to his GP ,outlining the above, and was ready for typing by the Friday. However on the Friday evening, a friend who was concerned about him and could not contact him, alerted neighbours who looked into his house using a ladder and saw him lying partially clothed on his bed. There was a smell of petrol fumes, and they called the police who forced an entry. He was dead, apparently by his own hand, having taken a number of Seroxat (anti-depressant previously prescribed several years ago), about 40 Prozac tablets, some Asprin (upto 30), one and three quarter bottles of whisky. There had also been a petrol generator running in the room, as there was a strong smell of fumes but it had run out of petrol: the lividity of the body indicated probably carbon monoxide poisoning as well. There was no suicide note, though a large number of emotional scribblings were present. The pathologist noted these thoughts to be indicative of a depressive illness.

In Scotland, there is no coroner's court or hearing. Legal responsibility for investigating suspicious deaths lies with the office of the Procurator Fiscal, who, after a police investigation, can decide to activate a Suspicious Death or Incident Inquiry, however these are quite rare. Additionally the Health Board (or Primary Care Trust) hold a Suicide Review Panel that looks at all suicides where the person involved had had any contact with psychiatric services within the previous six months. This covers about 20% of all suicides in the area. The written findings of the panel are made available to the office of the Procurator Fiscal, who may choose to make them available to the family, or to any later enquiry.

Recommendations from the panel are acted upon within the Health Board or Trust. The PET had also met together and discussed these events and I had already talked the situation over with the GP who referred him to me in the clinic and later to the PET, and we concluded that there was probably little more that we could have done, given the circumstances. The GP had also met with the PET doctor, Dr Reede. I had also rearranged a supervision session later in that week, which was helpful to me personally and emotionally. Again, there was a similar conclusion.

Such a Suicide Review Panel was called about 5 weeks after George's death. George's GP was away on annual holiday, as was the Psychiatric Staff Nurse. The panel, headed by the doctor responsible for these review panels, Dr 'Brown', and a member of the Health Board's Clinical Practice team, Mr 'Black', was attended by George's counsellor, myself; the consultant psychiatrist, Dr White; the SHO who had seen him last, Dr Reede; and the doctor in overall charge of the PET, Dr 'Gray'.

The various letters, the autopsy report, and so forth were available and were circulated. I also had my own session notes, made at the time of the session or immediately afterwards. Some time was spent ensuring that all the involved parties had accurately reported the sequence of events, largely outlined above. *What follows now is taken from largely from memory, plus a few scribbled notes at the time.*

There was an obvious concern that Dr Reede and the staff nurse in the Psychiatric Emergency Team might have missed something, or might even have made a different diagnosis. It is very easy, in retrospect, to be wise after the event. It is certain that there was a very significant difference between the GP's and the PET's viewpoint on the same person on the same day, and this discrepancy obviously needed to be addressed, given George's suicide just a few days later. There were, significantly, very different levels of disclosure from George: much more open to the doctor and much less so, even mendaciously, to the PET professionals. One possible reason for this could be that the PET is situated in an old Victorian hospital, with a mental health secure unit (locked ward) attached. Locally, it has a fairly fearsome reputation, due mainly to its history. After some discussion, acknowledging his known fear of a psychiatric admission and the implication to this to future job prospects, it was decided that the local reputation might have possibly added to his fear of being admitted, so he probably did not disclose fully to the PET team so as to get out again that evening. Little can be done about the public's fear and prejudice of mental health services, though attitudes are very slowly changing.

Because of the delay in the written letter reporting back to the GP, not good in such an emergency referral, it was decided to recommend the implementation of a new policy of contacting the referring GP immediately after such a referral, preferably when the person was still on the premises, or otherwise the next morning. In this particular case, because it was after 5.30pm, the GP would have gone home and been unavailable. Still, it was good to hear the willingness to examine procedures and look for changes.

There was also some discussion about the probable effects of coming off a medication (Trazodone) with sedation effects, onto a medication without (Prozac) and the interval in between. Unfortunately, George becomes another statistic here, as there is a known higher incidence of suicide when changing to an SSRI or changing doses of an SSRI (within 4 weeks). Perhaps more notice could have been taken of this timing, or more tranquillisers could have been given (not recommended policy for people potentially suicidal), but this is also a retrospective viewpoint: extra medication was indeed supplied.

There was then a discussion about whether, in this case, the obvious and overwhelming anxiety that George experienced was actually covering a depression. Given that he was already prescribed and taking Fluoxetin, and given the contra-indications of (his previously prescribed) SSRI, Seroxat, Fluoxetine would probably have been the first drug of choice for a diagnosed depression,. It is also unlikely that he would have been prescribed this any earlier, given new Health Board recommendations on the prescribing of SSRIs. Even with this extra diagnosis, possibly missed by the GP, Dr White, Dr Reede, and the Staff Nurse, would their actions have been any different? Would he perhaps have been retained – against his will, "sectioned," that Tuesday night? It was decided that this would have been very unlikely.

It is extremely unlikely that anything different would have actually happened, even though there may well be some retrospective learning points for the various health professionals involved. I am sure that the relatively young Dr Reede gained some very valuable experience and insight into such situations: he had obviously already considered and re-considered his impressions and actions of that evening, though there was no hint of any censure from the very experienced members of the panel.

In suicide enquiries, there is often a feeling that, if something else was known or something more had been done, the person could have been saved. This was mentioned, and it was also dismissed, as it is often nothing more than wishful thinking. Apparently most such enquiries do <u>not</u> show that events could or would have been significantly different if all circumstances had been known. Benefit can be gained without that and certain potentially productive items of learning had already come out of this review process. However there was a little more yet to come …

The consultant psychiatrist, Dr White, then informed the panel that, about a fortnight earlier, three weeks after the suicide, a long-term friend of George's, 'Ian Green' had contacted him wanting an appointment. Ian Green had then given him quite a lot of new information, which, if it were true, could be very pertinent to this enquiry. Apparently George had discussed his situation with Ian and one or two other close friends fairly frankly, and it was this information that Mr Green wished to communicate.

George had told them that, apparently, his father had sexually abused his two sisters and that this was only known within the family. This, in part, in turn, might have accounted for his mother's suicide

about 16 years ago, and might even account for some of their present antagonism and their desire to get 'something more' from their father's estate. We do not know why this antagonism might have been directed also towards George, but, if true, this information certainly shed some new light on a potentially catastrophic family dynamic. Again, according to Ian, George was fearful of these facts coming out in court as he thought that his sisters might disclose this information in their legal action against him as a justification for their claim. He was, apparently, quite scared of social reaction against him, as the son of his father, now potentially publicly a paedophile and child abuser.

There was a short discussion as to whether George himself might also have been a victim of sexual abuse, but there was no evidence of this (and some contra-indications), so it was felt that the family abuse was probably purely heterosexual.

Additionally, this friend, Ian Green, disclosed to Dr White that George had also admitted to him that, given his experience with Inland Revenue, he had been managing to avoid paying any Income Tax for about 10 years. He was very worried that this 'transgression' would also come out in court as his sisters were demanding sets of accounts so as to identify all the money that his father had given him over the last three or four years during the course of his father's illness (with the implication that he might have misappropriated some of his father's estate or abused his position as a carer in change of someone with dementia). George apparently was not so much worried about this latter point, as worried that his remaining capital would go in fines and penalties etc. to the Inland Revenue and he would be left destitute.

The final disclosure from Dr White was that Mr Green said that George had, the morning he committed suicide, received another letter from his sisters' solicitor saying effectively "see you in court". Perhaps this was the final straw.

After we had digested all this, somewhat shocked, reassessing the series of probably events, Dr Gray then commented that George had probably had had enough "life issues" to sink a battleship. It seemed fairly obvious that, given the information and limitations mentioned above, there was nothing different that the psychiatric medical or counselling services could have done; nothing would have saved this man. He was determined to end his life (witness the several extreme measures he took) and he was obviously overwhelmed by his (largely undisclosed) circumstances, his financial situation, the family dynamics, and his already expressed feelings of inability to cope.

In conclusion, I felt that the whole exercise of this panel was very useful. It had brought nearly everyone concerned together, and, as a result, we all learnt a lot. There were some definite points being taken away from this panel for the various individuals and teams, and the written report would also be made available to a wider circle. I did ask that the language in which the written report was made, and especially some of the later (third-hand) revelations, would be as respectful as possible to the surviving family. It also became very clear to me, as a psychotherapist & counsellor, that I had seriously underestimated his openness and frankness. Despite his pleasant nature and his seeming enthusiasm for counselling, he did not disclose some very pertinent material: not to me, nor to the G.P., nor to the psychiatrist, nor to any one of us. My conclusion is that it is probable that we only ever hear half of the real story from any client. I think that that is the main lesson that I took out of this situation.

In psychotherapeutic terms, suicide is considered, by some, as a very angry act: it is the ultimate "fuck you" to the rest of the world, to life, and – in some cases – to God as well. From this viewpoint, it is aggression channelled inward. Despite George's obvious aggression towards his sisters and their legal action, there are also several other theories, and perhaps George best fits into Shneidman's approach[1], which is worth quoting at greater length. His "Ten Commandments of Suicide" run as follows: 1 The common purpose of suicide is to seek a solution; 2 The common goal of suicide is the cessation of consciousness; 3 The common stimulus in suicide is intolerable psychological pain; 4 The common stressor in suicide is frustrated psychological needs; 5 The common emotion in suicide is hopelessness –

[1] Shneidman, E.S. (1987): A psychological approach to suicide. In G.R. VandenBos & B.K. Bryant (eds.) *Cataclysms, crises & catastrophes: Psychology in action.* Washington, D.C.: American Psychology Association: p. 167

helplessness; 6 The common cognitive state in suicide is ambivalence; 7 The common perceptual state in suicide is constriction; 8 The common action in suicide is egression; 9 The common interpersonal act in suicide is the communication of intention; 10 The common consistency in suicide is with lifelong coping patterns. George seems to fit into nearly all of these.

Neurochemical post-mortem studies show clear links to low levels of serotonin (its major metabolite 5-HIAA), irrespective of the diagnosis: of depression, schizophrenia or various personality disorders.[2] I am convinced that the point at which George was in the changeover of his medication (from Trazodone to Prozac) was indeed a significant contributory factor, however unavoidable. Again, this is being somewhat wise after the event, but this is also information that has been emphasised already in the public domain. SSRI medications do seem to carry extra risks, especially of suicide, before onset and at withdrawal, as well as at times of changes in the dosage. Maybe something more can be done here by ensuring a sedative period in the change over process.

Finally, my heart goes out to George's sisters. This family situation is on the epic scale of a Greek tragedy. For sure that it can be said (and has been said) that they hounded him to his death. However, if Mr Green's allegations were correct, they were also the victims of child sexual abuse. They had furthermore also lost their mother to this abuse. Recently, they had just lost their father, the alleged abuser. Perhaps, as a form of protest against many years of family silence, they initiated their tragic course of action. Maybe they wanted more justice; their day in court; recognition, and not just the money or the house. In retrospect, they were probably wrong. However, by their actions, somewhat unwittingly as they may have known nothing about the tax situation, they have now also lost their younger brother. As an epilogue, Ian Green reported that, at George's funeral service, in the small community where everyone knows each other, everyone sat on one side of the church, and they were sitting on their own, in total isolation. The air, he said, was charged and the atmosphere was palpable. So they may have gained a house, or got retribution, but they have probably lost all local community respect as well. I wonder what their learning is?

I wonder what your learning is?

This is written as something of a memorial to 'George'.

[2] Brown, G.L. & Goodwin, F.K. (1986): Cerebrospinal fluid correolates of suicide attempts and aggression. *Annuls of the New York Academy of Science*, 487, 175-188.