Learning from a suicide

by Courtenay Young

Counsellors and psychotherapists are like detectives. They scrutinise clues provided by the client, gather information from other professionals and make the best deduction possible in the circumstances. Sometimes the information proves to have been incomplete

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 20 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.

George* was referred by his GP with high levels of anxiety, low mood, and sleep problems. He was 47 and lived in the family house. He was being prescribed Trazodone, a tri-cyclic antidepressant with a sedative component, which only partially helped his anxiety. He presented as mild, gentle, calm, and very likeable. His anxiety was high but also internal. He did not appear depressed but had had one or two previous episodes of depression.

George's father had died (aged 68) of Parkinson's disease six months previously, and George had nursed him through his last years, giving up work semi-permanently. His mother had committed suicide when George was in his 20s. George had one sister who was married and a reasonable social life. He was single, though he'd had two heterosexual relationships of about four years duration each.

He was well educated and had previously worked for an accountancy firm for 10 years. Whenever his dad was feeling OK, George would go out walking on the hills. He drank about two pints of beer a day and did not smoke.

George described how one of his major worries was that his sister was now contesting their father's will, made many years earlier when their mother was still alive. George had been left the family house and half of the monetary estate. His sister – who also received half and had a house of her own – had recently taken out an injunction that prevented George selling the house and froze the monetary assets. She was 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, and stated that he was very worried he would lose the house and all his capital, and would have nowhere to live. He'd been out of work for four years and was worried – given his emotional state – about whether he could get back into proper employment. The anxiety seemed real and appropriate.

I saw him for about 11 sessions over five months, the spacing due to my caseload in the clinic. 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 the early sessions we discussed stress prevention strategies and I gave him some 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 fourth session the doctor had increased his Trazodone as the panic attacks were becoming more frequent. His anxiety levels rose 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, nothing much seemed to help, yet he said he was grateful for the sessions and enthusiastic about the therapeutic contact. I encouraged him to take more exercise and to try to get back to his former levels of fitness. We also discussed the possibility of him putting a deposit on a house as something to fall back on, and he was also fitfully doing up one room to rent out to ease his financial situation and give him some company. He reported feeling increasingly depressed about his situation, having very little energy and being woken at night by nervous tension. We used some cognitive techniques to stop the 'Yes, but' resistances to help and aspects of the depressive thinking spiral, which he often employed.

By the seventh session, four months into the treatment, he told me he had an appointment for a psychiatric assessment with a consultant psychiatrist, in a few weeks. He then asked for some extra private sessions. With the GP's agreement and informing my supervisor, at George's request, I arranged to see him privately. I saw him three times before his next health centre appointment. We worked on controlling his panic attacks, and he discussed a little more openly the relationship he'd had with his mother and sister. The family dynamic was not pretty, with his mother quite critical and dominant and his sister taking her cue from their mother. His father, apparently, was the only person who accepted him for who he was. He spoke also about how his mother's suicide had affected him.

Medication switch

The consultant recommended that he switch from Trazodone (which was not controlling his anxiety) to Fluoxetine or Prozac, a more conventional SSRI anti-anxiety and anti-depressant medication. The psychiatrist also referred him to another unit for an anxiety management group (this was never taken up as it was not available for some months). He further recommended that George explore possible retraining or employment opportunities, as he was 'under-diverted' at that time; and gave him some literature on anxiety and stress. No further appointment was thought necessary.

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

Two weeks later – two weeks after stopping Trazodone and switching to Prozac – he made an appointment with his GP about increasing levels of anxiety. He also reported some depression and suicidal ideation. The GP was very 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 and a Psychiatric Staff Nurse. They reported that he was 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 losing half a stone over two months, but reported that 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' but 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 he experienced at home, and with increased frequency outside, and especially when he dwelt on the past. When asked, he admitted to drinking about two glasses of wine most nights. However, that evening he smelt slightly of alcohol and was seen to have a silver flask in his pocket. On further questioning, no evidence showed any alcohol dependence syndrome or excessive use. A note was made to make a further careful assessment about excessive alcohol intake.

He was reported as being rational and coherent and in a friendly humour. He was mainly preoccupied with his father's will. There was no evidence of delusional ideation, formal thought disorders, or 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 was convinced that he had any significant depressive illness or underlying

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psychiatric morbidity that might have warranted a hospital admission. He was advised that Prozac might take six weeks to work, and a few Diazepam were prescribed to help cope with sleep and agitation. A diagnosis of ‘low risk’ was made. ‘He was not suicidal.’

That was Tuesday night. A letter from the team was written to his GP, outlining the above, and was ready for typing by Friday. 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 (prescribed several years ago), about 40 Prozac tablets, some aspirin (up to 30), and one-and-three-quarter bottles of whisky. There had been a petrol generator running in the room until it had run out of petrol and the lividity of the body indicated probable carbon monoxide poisoning.

There was no suicide note, but a large number of emotional scribblings. The pathologist noted these thoughts to be indicative of a depressive illness.

What happened next

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) holds a Suicide Review Panel that looks at all suicides where the person involved had any contact with psychiatric services within the previous six months. This covers about 20 per cent of all suicides in the area.

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. 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.

A Suicide Review Panel was called about five weeks after George’s death, attended by the doctor responsible for review panels, a member of the Health Board’s Clinical Practice team, me as George’s counsellor, the consultant psychiatrist, the SHO who had seen him last, and the doctor in overall charge of the PET.

The various letters, the autopsy report, and so forth 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 is taken largely from memory, plus a few scribbled notes at the time.

Panel discussion

There was an obvious concern that the psychiatrist and the staff nurse in the PET might have missed something, or might even have made a different diagnosis. It is very easy to be wise after the event but there was a significant difference between the GP’s and the PET’s viewpoint on the same person on the same day, and this discrepancy obviously should have been 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 is that the PET is situated in an old Victorian hospital, with a mental health secure unit attached and a fearsome reputation locally. This might have added to his fear of being admitted and consequent implications for job prospects, causing him not to disclose fully to the PET team.

Because of the delay in the written letter reporting back to the GP – not good in such an emergency referral – we 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 George’s 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 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 four weeks). Perhaps more notice could have been taken of this timing, or more tranquillisers 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 the obvious and overwhelming anxiety that George experienced was actually covering a depression. Given that he was already taking Fluoxetine, 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, the psychiatrist, 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 unlikely.

Nevertheless, there may well be some retrospective learning points for the various health professionals involved, though there was no hint of censure from the very experienced members of the panel.

What wasn't known at the time

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. Certain potentially productive items of learning had already come out of this review process. However there was more to come…

The consultant psychiatrist then informed the panel that, about a fortnight earlier, three weeks after the suicide, a long-term friend of George had contacted him wanting an appointment. His friend had then given the psychiatrist 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 him and one or two other close friends fairly frankly, and it was this information that his friend wished to communicate.

George had told them that his father had sexually abused his sister and that this was only known within the family. This, in turn, might have accounted for his mother's suicide, and even for some of the sister's present antagonism and desire to get more from her 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. Apparently, George was fearful of his sister disclosing this information in court.

His friend also disclosed to the psychiatrist that George had admitted to him that, given his work experience in accountancy, he had been managing to avoid paying any Income Tax for years. He was very worried that this 'transgression' would also come out in court as his sister was demanding sets of accounts so as to identify all the money that his father had given him over the last three years.

The final disclosure from George's friend was that prior to his suicide, George had received another letter from his sister's solicitor saying effectively 'see you in court'. Perhaps this was the final straw.

In the light of this new information, the panel concluded that there was probably nothing different that the psychiatric medical or counselling services could have done. I felt that the panel was useful: it had brought nearly everyone concerned together, and, as a result, we learnt a lot. It also became clear to me, as a psychotherapist and counsellor, that I had seriously overestimated George's openness and frankness.

Despite his pleasant nature and his seeming enthusiasm for counselling, George had failed to disclose some very pertinent material to me, the GP and the psychiatrist.

The main lesson I took from all this is that we probably only ever hear half the real story from any client.

**All names and possible identifiers have been changed.*

References

1. Shneidman ES.: A psychological approach to suicide. In VandenBos GR, Bryant BK. (eds) Cataclysms, crises and catastrophes: psychology in action. Washington, DC: American Psychology Association; 1987.

2. Brown GL, Goodwin, FK.: Cerebrospinal fluid correlates of suicide attempts and aggression. Annuls of the New York Academy of Science. 1986; 487:175-188.

Theoretical considerations

In psychotherapeutic terms, suicide is considered, by some, as the ultimate 'fuck you' to the rest of the world, to life, and – in some cases – to God. From this viewpoint, it is aggression channelled inward. Despite George's obvious aggression towards his sister and her legal action, there are also several other theories, and perhaps George best fits into Shneidman's approach[1]. His 'Ten Commandments of Suicide' are 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 – 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 seemed to fit into nearly all of these.

Neurochemical post-mortem studies show clear links to low levels of serotonin, irrespective of the diagnosis – depression, schizophrenia or various personality disorders.[2]

I am convinced that the point at which George found himself in the changeover of his medication (from Trazodone to Prozac) was a significant contributory factor, however unavoidable. This is information that has been emphasised already in the public domain: SSRI medications do carry extra risks, especially of suicide, and maybe more can be done to ensure a sedative period in the changeover process.