A Psychologist’s Journey to Understand Suicide

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I’ve been practicing almost 30 years. Three of my patients have died by suicide. I’ve been told that I have a reputation for working with patients who have chronic suicidal ideation. That’s not something I set out to do. Rather it feels like that part of the work has found me and followed me. In this article I describe the work I have done with a few patients who struggled with suicidal thoughts, including one who died by suicide. The lessons I learned along the way reflect the points in our companion article, Ten Questions to Promote Excellence. The themes in this article include:

1. Feelings about losing someone to suicide;
2. Alarism and dismissive stances vs. concerned alertness;
3. The power of therapeutic relationship and maintaining boundaries;
4. Questions of self-disclosure;
5. Remaining alert for signs of a change in acuity of suicidal ideation;
6. The importance of collaboration and support; and
7. What it means to walk in the shoes of a patient.

Recognizing Our Feelings about Loss and Suicide

The journey began when I was 14 years old. I learned then that my father’s death three years earlier was a suicide, not an auto accident or a heart attack as I had been told. I had been 10 years old; my parents were divorcing. My father’s parents divorced when he was young, and he said he would never be a weekend father as his father had been. He told me he wanted to take me to another city and raise me (but not my younger siblings). But that was 1969 and there was little chance a father could get custody of a child. So instead he took me and ran away to Europe for three months. When he realized that was unsatisfactory, he brought me home to my mother, then took his life.

The feelings I had were complicated by the delay in learning the nature of my father’s death. Initially, my feelings were about the loss. The details of his death weren’t a factor, since I didn’t have accurate information about it. It took a few years for me to realize that I was embarrassed. Although I certainly didn’t have any feelings of responsibility for it, I also didn’t want people to know about it.

Despite this, my life after my father’s death worked out pretty well. I think this helped me through the later experience of loss when a patient died by suicide. It made it easier to go on working, because when someone dies by any means, our own journey continues.

On Becoming an Alarist

As discussed in the companion article, when working with suicidal patients, one should avoid taking an alarmist stance, overreacting to every indication of suicidal risk. The other pole, a dismissive attitude, is just as problematic. The goal is to adopt a position of concerned alertness.

I had the experience of the alarmist stance during my first external training practicum. I was placed at an alcohol treatment facility in a small town about an hour away. One of our faculty worked part-time as the psychologist in the facility. On days when the psychologist was not on premises, I had responsibility to assess the mental status of newly admitted patients. If there was a question about safety, I was to call the psychologist and review my findings with him. Four times during the year, patients were admitted who had suicidal ideation and were unwilling to contract for safety. All four times, I recommended transfer to an inpatient psychiatric facility, which meant tying up a staff person for most of a day. The director of the facility became increasingly irritated. She was obligated to follow the psychologist’s decision and my supervisor felt he had to back up his student. In retrospect, I doubt a skilled clinician would have hospitalized any of the four patients, but I understood that my job was to err on the side of safety.

Learning the Dismissive Stance

My graduate program had one course cross-listed with the law school and co-taught by a professor from the Psychology Department and the Law School. For the psychology students, the course was our ethics class. The Psychology professor introduced us to Thomas Szasz. He suggested that suicide is a rational decision which an individual has a right to make without interference. It was eye-opening to consider what it would mean to choose not to intervene with a patient who declared intent to die by suicide. Yet it was also a lesson in the limits of taking responsibility for another person’s decisions.

Learning to Exercise Concerned alertness

I came to Philadelphia for a pre-doctoral internship at Temple University Hospital. On the first day of the internship, each intern was assigned a number of outpatients transferred from the previous intern class. One patient had been receiving services in the clinic for several years. Each year she became attached to her therapist and was upset when the therapist left. Each year, she had a suicide attempt in the late summer or early fall, just after her therapist left. This year was no different. Maggie was admitted to the hospital with cardiac symptoms. She called me to say that she had taken an overdose of medication while she was in the hospital; she asked me to promise not to tell her other doctors. I told her that I was going to have to let her doctor know what she had done. There seemed to be clear ambivalence on her part. She was genuinely distressed with her difficult life, poverty and a husband who was both medically fragile and emotionally and physically abusive. On the other hand, Maggie valued the relationship with a therapist who cared and who listened non-judgmentally. So, the suicidal behavior was both an expression of her distress and a test of whether the new therapist cared.

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1. All the patient names used in this article are pseudonyms.
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Other patients that year presented with suicidal ideation. Some presented a serious risk of suicide. A dismissive position wasn't going to work. But neither would an alarmist stance. In this year, I learned much more about using the therapeutic relationship in the service of the growing health of the patient. I helped Maggie prepare for the coming transition at the end of my internship year. There were other patients who struggled with suicidal ideation; one needed to be hospitalized involuntarily. And there were chances to help psychiatric residents learn about believing the trauma in their patients' histories.

A Supportive Community

Susan was a patient in a clinic where I was working part-time. She had grown up with a mother who was chronically suicidal. She described coming home from middle school, never knowing whether her mother had attempted suicide that day. Susan was unhappy in her marriage, but she felt trapped. As she became increasingly suicidal, I encouraged her to accept a voluntary hospital admission. She regretted it; it was humiliating and did nothing to help. But she hung in there with therapy. I was worried. I offered two, sometimes three sessions a week. It helped that I had a pretty good working relationship with her treating psychiatrist and I talked about her regularly in my peer consultation group. Eventually she left her marriage. Although she was glad she had left, her depression didn't improve. She complained about the stress in her job. I recommended that she take a medical leave of absence. There was some improvement in her depression. The most helpful thing about the leave of absence was hearing how much she had been missed and needed while she was out. But one stressful day at work, she threw her keys on the desk and walked out. Her boss had apparently had enough. She was told that leaving her keys and walking out constituted a resignation, which had not been her intent. Her lawyer told her that her employer would likely win a legal challenge. With her permission, I spoke with human resources, asking that the 'resignation' be turned into a disability leave. They refused.

Susan's suicidal ideation escalated with her unemployment. We were doing frequent, sometimes daily telephone check-ins. I had contact with her adult daughter (with permission), who was worried about her. There was an involuntary hospitalization. Initiating that meant driving to the crisis center, completing paperwork, waiting for the county advocate to approve it, then driving the signed documents to the police department. It did add to my sense of professionalism that the crisis center staff said that they tend to support a treating psychologist who knows a patient well. After that hospitalization, things didn't get any better. One day I started getting a series of increasingly frantic phone calls from her daughter. Susan was missing. Susan was found Monday morning. She had taken her life in the parking lot of the building where she had previously worked. It was likely that I was the last person she had spoken with, assuring me that she was safe during a Saturday telephone check-in.

I was stunned and I think I processed the loss a little bit at a time. I worried about mistakes I had made. Especially about having been lax about boundaries with Susan. I found myself focusing on small details, like the fact that Susan died by the same means as my father. I found myself suddenly certain that I had told Susan about my father and that she had purposely chosen that method. In retrospect, I realize that I did no such thing. I spent some time talking with her treating psychiatrist. I also got support from a peer in my consultation group, and from other colleagues. One colleague suggested that I speak with PPA staff person Sam Knapp. All these consultations were helpful.

Susan's story comes back to me at times, sometimes suddenly and unexpectedly. Last year, I was invited to participate on a panel of psychologists who have lost a patient to suicide. The panel organizer encouraged me to tie my experience with Susan to the loss of my father. Despite preparatory discussions, I was flooded with sadness during the actual presentation.

Heeding A Message

I worked with Diane for about 2½ years. She was a young doctoral candidate who was disabled with a painful medical condition. She was also chronically depressed with periods of suicidal ideation. She had numerous psychiatric hospital admissions, always voluntary, as she tried to find the cocktail of medications which would bring her relief.

As Diane's medical condition became worse and her pain became more intractable, her suicidal ideation became more chronic. A student of philosophy, she wanted me to affirm that sometimes a decision to die is a rational choice. I was reluctant to do so, afraid of where such a discussion might lead. But Diane always denied imminent intent to harm herself and I didn't see her as having acquired capability. (I hadn't heard that as a named concept yet.) Further, when things got bad, Diane sought hospitalization, searching for relief rather than escape.

One day I picked up a phone message, 'Please tell my parents I'm sorry.' No name, no caller ID, and the voice was faint, but I thought it was Diane. It was the middle of the afternoon and I had a couple more appointments. I wasn't sure what to do. During a break, I called a colleague, who offered only ambiguous guidance. I was distracted but finished two appointments. I probably shouldn't have. I drove to her home. Her car was there, the lights were out, and no one answered the door. I called the police department's non-emergency number. The dispatcher suggested that an officer could be dispatched for a "well-check." The police officer who responded was a kind man, probably in his 50s. He seemed comfortable dealing with a psychiatric emergency. He banged on the door and walked around the house. No response. We discussed our options. He could force the door. If she was home, it would be a good thing. If she wasn't, we would have egg on our faces and there would be damage to repair. He got the landlord's contact information from the Township Building, but the landlord couldn't be reached. I asked what would happen if I told him I believed the patient was suicidal. He told me that if I said those words, he would be forced to enter the house. We looked around again. It was dark by this time.

As he shined his flashlight into the living room, the cat jumped up to investigate, pushing back the curtain enough to see the keys on the table, confirming that Diane was at home. The police officer said that the fire department had a new tool which would allow entry with minimal damage. Unfortunately, it was fire department policy that every call was answered in force. Three fire trucks showed up in full emergency mode for a job that could have been done quietly by one person. Now all the neighbors were watching. The door was opened, and the officer entered the house, instructing me to wait outside. Diane was inside, unconscious, with empty pill bottles by her bedside.

I called Diane's parents to let them know she was in ICU. I also called
her primary care physician. The physician was stunned. She had seen Diane that day and Diane's depression seemed better. She gave no indication of being suicidal. In fact, Diane had asked for and received a flu shot about two hours before she took a nearly fatal overdose of pain and antidepressant medication. It took a week or so for Diane to recover medically. She moved away shortly after that, and after a couple of years she was married to a man who had been a friend for many years. She sent me Christmas cards with updates for several years. She said that she had found happiness, in spite of her pain. It also seemed that she had also found more effective treatment for her pain.

**Permission To Die**

Sally was in her 40s. She described a history of repeated childhood abuse, including sexual abuse by a treating pediatrician. She self-injured in ways that seemed to reenact her childhood abuse. She was chronically suicidal and skilled at engaging a therapist in directions that weren't helpful. Sally believed that she was bad, a quality she believed to be inherent in every cell of her body, just like being female exists in every cell of the body. I got drawn into debates about what it means to be bad, whether being bad was relative or absolute and whether it was remediable. She had a career in the medical field, was well respected in her hospital and was responsible for saving many lives. But that didn't change her belief that she was bad. It seemed like therapy was going nowhere. There was a period when Sally's suicidal thoughts rose to a crisis level. She called me one day and it seemed clear she intended to end her life. I called the crisis center nearest her home. They informed me there was nothing they or I could do, since the phone call from Sally had been across state lines. They suggested that if Sally repeated her suicidal statements in my office, then I would be able to act here in Pennsylvania.

My next appointment with Sally was three days later. We had daily phone contact in the interim. I was not reassured by the phone calls. Sally was scheduled for an evening appointment. I called the local police department serving my office and let them know that I had a potential emergency brewing. Sally came to the appointment and it was clear she intended to die. She asked me repeatedly to tell her it was okay for her to die. She refused voluntary hospitalization. She pleaded her case that sometimes emotional pain is too great to endure. She grew frustrated that I wouldn't give her my blessing to end her life. It was especially frightening that Sally intended to kill herself by driving her small car into a much larger oncoming vehicle, in the belief that she would die, and the other driver would be uninjured.

The second office in my suite was vacant but furnished. Sometimes Sally used the room when she didn't feel safe to leave at the end of an appointment. I let her into the spare office and without tipping my hand, I called the police. She was transported to the crisis center. I followed in my car to complete an affidavit for an evaluation for involuntary hospitalization. Sally was interviewed by the Crisis Center psychiatrist and released that night, having convinced him that she was not imminently suicidal. When I next saw Sally, she admitted that she had in fact intended to kill herself that night. She said that she understood why I took the action I had, but she was hurt and angry that I had been distant and unsupportive once the police arrived. I explained that I was trying to stay out of the way and not interfere with the police. And I hadn't seen her in the crisis center because I didn't think that was permitted. Sally saw me a couple more times, but it was clear that she had disengaged. She stopped scheduling appointments and didn't respond to phone calls.

One of the dangers of making the choice to seek involuntary hospitalization for patients is that they will be so angry that they will not return to treatment. Sally had dropped out of treatment, in contrast to Susan who was angry but continued in treatment. The therapeutic alliance with Susan was sufficient to carry us through the crisis of hospitalization. The outcome was different with Sally.

**Self-disclosure in Psychotherapy**

A therapist should be cautious about self-disclosure in therapy. Self-disclosure should always be in the service of the therapy and should not occur when doing so detracts from the therapy or makes the therapy more about the therapist than about the patient. I met Brandon about a year after he returned from his last deployment to Iraq. He was having flashbacks and he was angry too often. His marriage was shaky, and he couldn't connect with a teenage stepson who was far from following Brandon's warrior model. From the outset he questioned how therapy could help and whether he should even be talking about such things with an outsider who had never served. In the first session, Brandon talked about how lost he had been after his father's suicide and how he had contributed to his journey to becoming a warrior. I made the decision at the end of the first session to disclose my own father's death by suicide at about the same age that Brandon's father had died. When Brandon returned, he told me that my disclosure was key to his decision to give therapy a try. Up to that point, he was convinced that I could never understand his experience and that I would never be able to connect with him. We went on to work together off and on for a few years.

**Lessons Learned**

Some of these experiences have touched me more deeply than others. It has indeed been a journey of learning, and of understanding. The deepest understanding has been about my own reactions and my own emotions. Along with that has been a deepening understanding of the lives, experiences, and feelings of those I sit with in the therapy office.

When I look back, what I tend to see is my lack of skill. But when I share these experiences with colleagues, they see the lack of guidance I had available to me, and the ways I have incorporated what I learned into my daily practice. I am embarrassed by the poor boundaries early on. I heard many times that I was good with chronically suicidal people and that some community referral sources directed such patients to me. That was something I didn't want to hear, although I was also proud of it. In retrospect, much of what I was doing was consistent with the principles of the recovery movement and of the Interpersonal Theory for managing suicidal patients.

Key lessons have been about the importance of the therapeutic alliance, especially when a patient has thoughts of suicide. I have learned that the therapeutic alliance is helpful, not harmed by maintaining firm and gentle boundaries. I have learned that alarmist behavior doesn't keep patients alive any more than being dismissive of a patient's distress and risk-level. I have refined my skills in maintaining concerned alertness. I also learned about the dangers of making the decision to seek

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Involuntary hospitalization. Some patients will be angry but will return to therapy to work through the disruption to the therapeutic relationship. For others, like Sally, the relationship is beyond repair.

Most importantly, I have learned how little control we have over the decisions our patients make. We can be persistent and plant seeds of hope for change and a better life. However, we cannot prevent all suicides. Sometimes, our patients will act on their need to escape pain and discomfort. The best we can do is to be present for them and apply our knowledge and our skills to minimize risk.

Sharing my Learning

I worked for a few years in a residential treatment center. That was both an opportunity for more training (a broader introduction to the skills training component of Dialectical Behavioral Therapy, for example), and a chance to see that I was in fact skilled in this area. Suicidal crises were common in this program which treated the most intensely high-risk patients, and in fact there were deaths. Past experiences with patients who struggle with suicidal ideation helped me to sit with patients as they struggled with their traumas, sense of being trapped, and wish for escape by any means. Part of my role in the facility was to help case managers and other staff to learn to work with such high-risk patients, and to help them cope when a suicide attempt or a death occurred. I shared my own experiences and offered consultation about boundaries, about the central role of the therapeutic alliance in preventing suicide, and about concerned alertness versus the polar stances of alarmist and dismissive attitudes.

In the past couple of years, I have become more active in PPA leadership. As I described above, I had the opportunity to share some of my experiences and the lessons learned as a member of a panel at the 2018 Annual PPA Convention. More recently, I have had the opportunity to co-present some of these lessons with Dr. Sam Knapp, who had helped me through the aftermath of a client suicide 18 years earlier. I will continue to share my learning, to help colleagues, including younger psychologists learn lessons that will increase the chances a patient with suicidal ideation will live, avoid some of the pitfalls, and perhaps learn from my mistakes and my successes. I will continue to share what I have learned because none of us can do this work alone.