Addressing The Unthinkable

How You Can Constructively Deal with the Problem of Suicide

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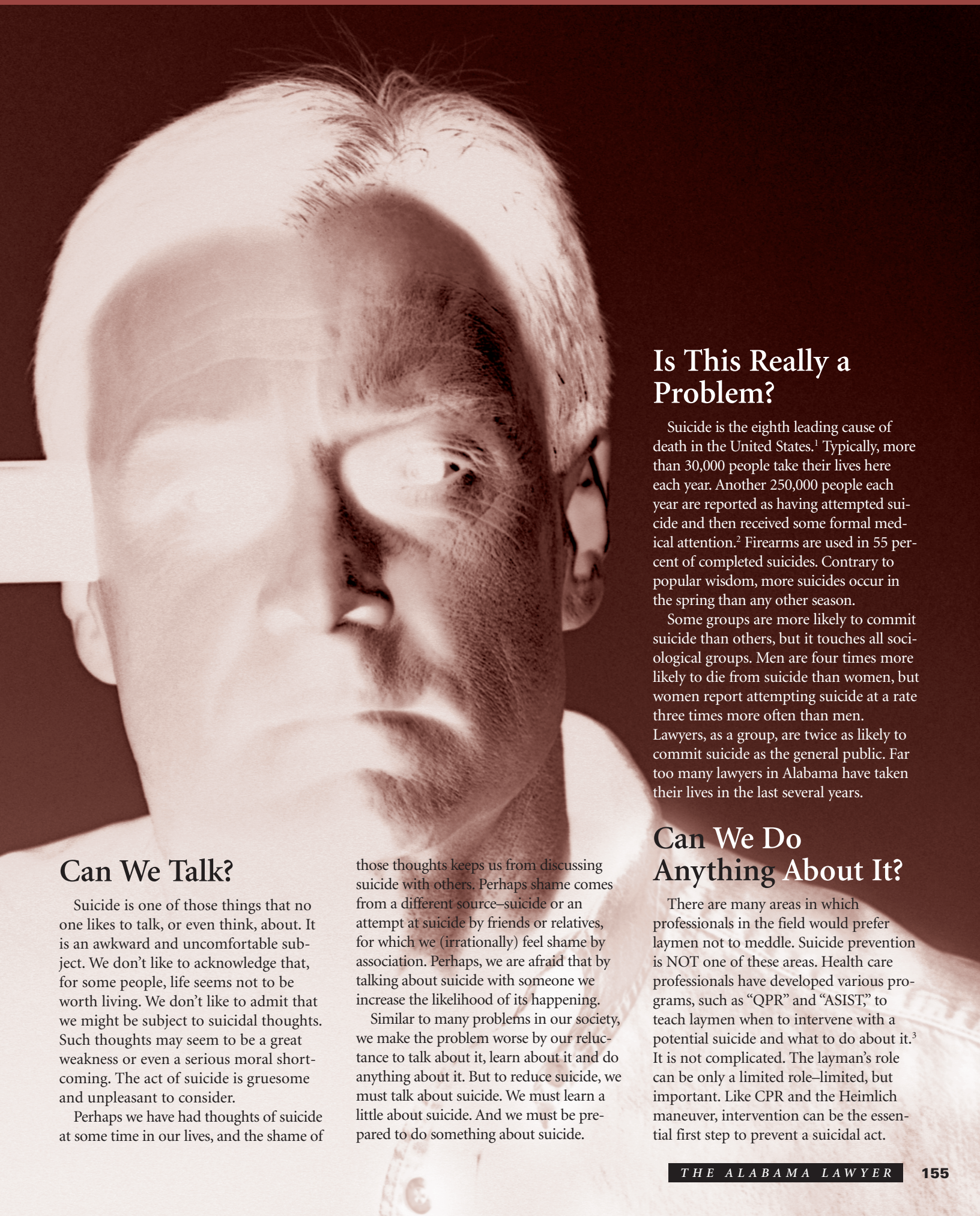

Can We Talk?

Suicide is one of those things that no one likes to talk, or even think, about. It is an awkward and uncomfortable subject. We don't like to acknowledge that, for some people, life seems not to be worth living. We don't like to admit that we might be subject to suicidal thoughts. Such thoughts may seem to be a great weakness or even a serious moral shortcoming. The act of suicide is gruesome and unpleasant to consider.

Perhaps we have had thoughts of suicide at some time in our lives, and the shame of those thoughts keeps us from discussing suicide with others. Perhaps shame comes from a different source–suicide or an attempt at suicide by friends or relatives, for which we (irrationally) feel shame by association. Perhaps, we are afraid that by talking about suicide with someone we increase the likelihood of its happening.

Similar to many problems in our society, we make the problem worse by our reluctance to talk about it, learn about it and do anything about it. But to reduce suicide, we must talk about suicide. We must learn a little about suicide. And we must be prepared to do something about suicide.

Is This Really a Problem?

Suicide is the eighth leading cause of death in the United States.[1] Typically, more than 30,000 people take their lives here each year. Another 250,000 people each year are reported as having attempted suicide and then received some formal medical attention.[2] Firearms are used in 55 percent of completed suicides. Contrary to popular wisdom, more suicides occur in the spring than any other season.

Some groups are more likely to commit suicide than others, but it touches all sociological groups. Men are four times more likely to die from suicide than women, but women report attempting suicide at a rate three times more often than men. Lawyers, as a group, are twice as likely to commit suicide as the general public. Far too many lawyers in Alabama have taken their lives in the last several years.

Can We Do Anything About It?

There are many areas in which professionals in the field would prefer laymen not to meddle. Suicide prevention is NOT one of these areas. Health care professionals have developed various programs, such as "QPR" and "ASIST," to teach laymen when to intervene with a potential suicide and what to do about it.[3] It is not complicated. The layman's role can be only a limited role–limited, but important. Like CPR and the Heimlich maneuver, intervention can be the essential first step to prevent a suicidal act.

The first premise of intervention is the finding by researchers that most individuals who attempted suicide gave identifiable signs to one or more persons in the weeks before the act. The signs were not made solely in the presence of family and close friends, but often were given to coworkers or acquaintances in contact with the individual during this critical period.

The second premise is that even a modest contact with another person–if of the right kind–can dissuade the person from acting, for at least a short critical period. With followup attention by health care professionals, the suicide can usually be avoided altogether.

Spotting the Problem

There is nothing we can do, if we cannot identify a person who may be at risk of suicide. Identifying such people is difficult, and it can never be certain. You should be willing to act on a reasonable suspicion; certainty is not necessary. There can be little harm done, and much good, by merely expressing your concern for another person's health and feelings.

However, this is a great barrier to identifying people at risk–few of us want to believe that the person facing us is capable of suicide. On some level of consciousness, many of us really do not want to see any symptoms. Moreover, many of us don't like to get involved in the personal lives and emotional problems of others. Ignorance is not bliss, if you later realize you might have saved a person's life merely by showing a little concern.

We must get past this reluctance. We can quickly learn to recognize the symptoms. And our modest involvement in intervention can and will saves lives among our colleagues, friends and family members.

There are a number of signs that may indicate that a person is at risk. Not all people at risk will exhibit all, or even any, of these signs. Furthermore, many people who are *not* at risk may exhibit many of these signs. Remember that certainty is not required; suspicion is sufficient for action. You action is not offensive; it is merely a caring inquiry. Reluctance to act, for fear of being wrong, is usually unjustified, and in some cases will be fatal.

The following are lists of most common signs of depression[4] and potential suicidal thoughts. The signs fall into categories:

- The individual may provide obvious direct verbal clues like these:
  - "I've decided to kill myself"
  - "I wish I were dead"
  - "I'm going to end it all"
  - "I'm going to commit suicide"
  - "If such and such doesn't happen, I'll kill myself"
- More often the individual gives only indirect or coded verbal cues like these:
  - "I'm tired of life"
  - "What's the point of going on"
  - "My family would be better off without me"
  - "Who cares if I'm dead"
  - "I can't go on anymore"
  - "I just want out"
  - "You would be better off without me"
  - "Nobody needs me anymore"
  - "I don't fit in anymore"
  - Other statements reflect hopelessness or preoccupation with death.
- Many clues are behavioral, such as these:
  - Abrupt changes in personality
  - Pervasive, exaggerated or inappropriate displays of sadness or anger
  - Inability to tolerate frustration or to cope with stress
  - Withdrawal or unwillingness to communicate
  - Eating disturbances or significant weight changes
  - Sleeping disturbances
  - Abruptly putting business affairs in order or changing a will
  - Sudden happiness in a depressed person may be signal of suicide[5]
  - Unusual reckless or self-destructive behavior, such as sexual promiscuity or excessive use of drugs and/or alcohol
  - Depression or unusual sadness, discouragement or loneliness
  - Extreme or extended boredom
  - Inability to concentrate
  - Unusually long reactions to grief
  - Neglect of work
  - Neglect of personal appearance
  - Giving away prized possessions or donating body to medical school
  - Ceasing activities that they once loved
  - Buying a gun for the first time
  - Stockpiling pills
- Some situations should increase your concern from other clues:
  - Ending a marriage, divorce or separation
  - Ending a romance or long-term relationship
  - Death of someone close (especially if by suicide)
  - Serious illness or trauma to self or loved one
  - Previous suicide attempt
  - Sudden rejection or unexpected separation
  - Diagnosis of terminal illness
  - Anticipated loss of financial security or personal freedom
  - Loss of status, prestige or identity

What Can We Do?– The "QPR" Model

It is a myth that suicide can't be prevented. It can. QPR is one technique that works. QPR stands for "Question" (them about suicide), "Persuade" (them to get help) and "Refer" (them for help). Research shows that the great majority of those who attempt suicide give some signal first. Yet, those in a position to do something about it are often reluctant to get involved.

When deciding whether to intervene, to ask about thoughts or plans for suicide, to break a confidence about a friend's thoughts or plans of suicide–the best rule is safety first. Conflicts, discomforts and embarrassments are resolved much more readily than the pain of losing someone to premature death. Sometimes, because the

thought of death is frightening, we deny the person may be suicidal. Overcoming the denial is an important step.

QUESTION

The first step in the QPR Model is to *question*. Get the person alone or in a private setting and, ultimately, ask them if they are contemplating suicide. You might start by asking questions that express your concern and acknowledge the individual's distress, questions like: "Have you been unhappy lately?" "I've noticed recently that . . .." "I've been concerned about you. How are you feeling?"

Ultimately, you must ask the "*suicide question*" directly: "Do you want to stop living," or "Has it been so bad that you've thought about suicide?" It is important that you directly ask about suicide. Do not be afraid to use the word. Asking the "suicide question" does not increase the risk. Asking actually reduces the risk of suicidal action: first, because it opens the door to help, and, second, because asking conveys an implicit message to suffering individuals that someone cares deeply and that they do not have to be alone in their pain.

After asking the questions, you must actively listen to the responses and concerns. You must be sincere, supportive and understanding. Avoid the lawyer's professional pitfall–giving advice. Advice tends to be easy, quick, cheap and wrong. Listening takes time, patience and courage, but it is always right. Give your full attention and don't interrupt the individual. Do not judge or condemn him. Listen particularly for the problems that he believes death by suicide would solve.

You may conclude that the individual is not suicidal and no further action is needed. The individual will probably appreciate your concern, although admittedly there may be an awkward moment. Or you may get evasion and denial, perhaps even some anger. You must evaluate these responses for yourself, and may conclude that no action is needed.

An affirmative answer opens the door to further action and often is a release for the individual. It can make them feel better, not worse, for getting it in the open. The suicide question is now on the table for discussion. But that also means that you have more work to do.

PERSUADE

The second step is to *persuade* the individual to get help, to get the person to say, *yes,* they will get help. For example, ask: "Will you go with me to see a counselor (doctor, priest, rabbi, minister, nurse, etc.)?" "Will you let me help you make an appointment with . . .." or "Will you promise me to talk to . . .." Accept the reality of the person's pain.

Sometimes, a person will agree to get help. Others may resist the idea. If there is resistance, you might make a "no-suicide" contract with the individual–a promise not to hurt himself until help is sought. Because making a promise appeals to one's honor, and because agreeing to stay safe offers some relief, the answer is usually yes. Thereafter, continue to express your concern and revisit the idea of getting help.

If the individual refuses, decide if he may be a danger to himself or others. You must decide if unilateral action is appropriate. Err on the side of safety. Commitment might ultimately be necessary, but more immediate emergency medical help may be most appropriate. Take the person to an emergency room. Call 911. Do not worry about being disloyal. You are trying to save a life. Do not worry about breaking a trust or not having enough information to call for help.

There are other things to consider. Remove firearms, car keys, medications, knives, and other instruments which may be used to commit suicide. By restricting access to the means of suicide you buy time for another solution to be found. Removing the means to suicide is, in itself, an act of hope.

If someone is contemplating suicide, keep him sober. People who take their lives have to overcome a psychological barrier before they act. This final wall of resistance is what keeps many seriously suicidal people alive. Alcohol dissolves this wall and is found in the blood of most completed suicides.

All of us can challenge an individual's belief that he is a burden or will never fit in. We can reinforce the individual's reasons for living. Remember that small acts of acknowledgement, appreciation and kindness can have tremendous impact on someone in crisis.

REFER

The final step is QPR is to make a "referral." Get the person to someone who can help. Call a crisis line for referrals, or seek the other resources listed in this issue. Go with the individual, and do not leave her alone. The best referrals are when you personally take the person you are worried about to the appropriate professional.

No one in the great emotional pain that such a person feels should be alone with that pain. Also, you should not be alone in the effort to support a desperate person. Sources of immediate help include crisis lines, hospitals, physicians, therapists, and the referral and treatment resources available through lawyer assistance programs. After the crisis, 12-step programs such as Alcoholics Anonymous and mentoring by volunteer lawyers have proved invaluable to attorneys recovering from the mental illness and substance abuse problems often associated with suicidal thinking and behavior. ■

Endnotes

1. The data is from the Web sites of the Centers for Disease Control. Suicide is the third most common cause of death for young people ages 15-24. The rate of suicide among this group is roughly 4,000 out of the 30,000 total suicide deaths each year.
2. However, the number of unreported attempts is believed to be considerably greater.
3. The "QPR" Program, discussed below, is just one of several such programs. Discussion of QPR should not be considered an endorsement of QPR over the other programs.
4. Most of these signs are also those of clinical depression. It is no surprise that depression generally accompanies suicidal thoughts.
5. Since depression saps energy and purpose, sometimes a depressed person is "too tired" to carry out a suicide plan. However, as the depression begins to lift, the person may suddenly feel "well enough" to act.

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