In the Moment

Dave's Dead! Personal Tragedy Leading a Call to Action in Preventing Suicide

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I was waiting at the airport talking to an old friend. I was looking forward to the trip to Philadelphia to attend a medical convention, meet old friends, and share with colleagues. An overhead page came that I did not even hear. One of my colleagues said it was for me and I went up to the desk. This was the first call I had ever received at an airport check-in site and I was anxious. A captain from the West Allis Fire Department told me, "You have a family emergency. You need to come home right now." My anxiety level went sky-high. I found the energy to tell a colleague that I couldn't go to Philadelphia and what waited for me at home was probably going to be awful. As I drove home, I became more anxious with every block. My fears escalated when I approached the house and saw several police cars. I hurried inside. Before I even got up the steps, my wife was there and her demeanor said everything. The words confirmed my worst fears, "Tim, he's gone!" Our son had died by suicide.

I don't know if this is every parent's worst fear, but it certainly is up there. Through this essay I hope to provide a perspective that most physicians hopefully will never have to personally experience, to help pediatricians provide support to families on the worst day of their life, and to heighten awareness of this important public health issue.

The rest of March 4, 2005 is both a blur and indelibly etched in memory. Grief paralyzed our family. But tasks had to be completed. My wife and I began calling family, friends, and colleagues. Each call was no more than 2 minutes long, with us barely being able to say the words that Dave was dead and that we would call back. Our house was now a crime scene. The police were still there, and the medical examiner had yet to come. When the medical examiner came and did his evaluation, he spoke to us in kind but difficult words. He expressed his condolences–I knew he must have gone through this many times before. For me, once was more than enough for a lifetime. There is almost nothing I can imagine as awful as seeing my son carried away in a body bag.

Unfortunately, suicide is not a rare event and rates are increasing. Suicide is the third leading cause of death in children aged 10 to 19 years. Preliminary data for the United States 2004 population identified over 32 000 deaths by suicide, including almost 2000 between the ages of 10 to 19. And yet there is very little written about the issue in the pediatric literature. An Ovid MEDLINE search for articles on pediatric suicide published between 1995 through 2006 showed a single report in *Ambulatory Pediatrics*. Suicide is also a neglected topic in pediatric training and research and is rarely presented at our academic societies' meetings. We have left the topic of suicide to mental health professionals. But it must be recognized as both a public health and a pediatric issue.

Pediatricians should know that risk factors for suicide include male gender, prior suicide attempts, family history of suicide or affective disorder, substance abuse, and past history of abuse. Twin studies are especially striking for suicidality. Patients who have bipolar illness are at particular risk, with an annual suicide death rate of 1% and a 10-fold higher rate of completed suicide compared to the general public. Unfortunately, our son had many of these risk factors, including bipolar illness and previous life-threatening suicide attempts.

Completed suicide leads to overwhelming guilt in those left behind. Mental illness carries a stigma, and suicide's stigma is even greater. Parents and family are hesitant to tell others that a loved one has died by suicide. The guilt often starts with the concept that suicide is a sin. "Thou shalt not kill." Guilt also stems from the idea that the parents must have failed in some way if their own child would take his/her own life, an act seemingly incomprehensible to a rational person. This guilt is a challenge that pediatricians must recognize and address. If suffering ourselves, we need to be able to open up to others. We need to view suicide as a medical problem, be present for families, and show that we care.

In many respects, getting through the initial shock and the funeral was easier than what followed. The first week was busy—filled with making arrangements, having family fly in, getting together with loved ones, and attending services. Afterwards, when family left, intense and complicated grieving began. Grieving is work, and it is complicated when one is faced with a sudden unexpected

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death such as that caused by injury or suicide. We could not have anticipated this or prepared ourselves emotionally ahead of time.

Because I had always been a hardworking physician, I assumed I would be ready to go back to work full time within 2 months. How wrong I was. It has taken me 2 years to get back almost to baseline. An important lesson I learned was that everyone grieves at his or her own pace. I started back to work slowly, but patient encounters frequently reminded me of my son Dave and my grieving. In the first month back, one parent gave me great advice. Her son had died due to a serious infection 2 years before. She said, "Dr Schum, you will never get over this, but you will get through it." Those words have sustained me every day, as they are a reminder that others have grieved and eventually functioned normally.

The fact that I am a doctor made my grieving even more difficult. My life is dedicated to caring for children, adolescents, and families. Yet I couldn't *save* my own son. When grieving, almost anything can set you off. And in a doctor's case, there are triggers everywhere. There are increased contacts with children and adolescents having similar illnesses. A patient I saw in the first month after I returned to work carries a diagnosis of bipolar illness. This was very painful. As a doctor I understood the medical aspects of the illness—but from a totally different perspective—I was a parent of a teen who had bipolar illness and who had then died by suicide. How could I reassure them that their daughter wouldn't follow the same path? In my present state, I couldn't.

Each day when I go to work, I do not know whether I'm going to meet a teenager who has previously tried to cut himself or herself or attempted suicide. Over time, I have realized there are some high-risk settings for me: the emergency room, dealing with patients and parents of children who have mental illness, and encounters involving the police. As pediatricians, the numbers of phone calls we get can be overwhelming. In my situation, phone phobia is magnified. Now when I receive a phone call, whether from a patient or not, I wonder if it will be another one that will change my life. For the grieving doctor, on days when you have emotional energy and reasonable mood, you can handle these cases in the way we were trained. On the other days, coping is hard.

Part of the difficulty of coping with suicide is trying to understand it. It is a foreign concept to most of us. How could someone take his or her own life? Smolin and Guinan, in their insightful book, "*Healing After the Suicide of a Loved One*," provide some consolation: "It [suicide] must be viewed as the worst of choices made by a mind no longer able to function in a rational manner.[1]" The idea that a child reaches a point where he or she no longer has rational thought should drive all of us to do more. We must look for precursors to this mental state such as depression, extreme stress, and bipolar illness. By overcoming our own prejudices and guilt about suicide, pediatricians can help parents get through theirs.

Through this tragedy, I have discovered important resources for coping and moving on. There are support groups for parents, children, siblings, and friends of those who have committed suicide. One of the best known of these is Survivors of Suicide.[2] Many local chapters exist, filled with dedicated individuals who have lost loved ones to suicide. These groups meet regularly for support and sharing of individual stories. Many derive comfort just hearing from others who have experienced the same nightmare and knowing they are not alone. For others, these groups can be too overpowering during the initial period, and participation may add to their grief. The National Alliance on Mental Illness helps sponsor such groups and provides mental health resources to those affected by suicide.[3] The American Foundation for Suicide Prevention sponsors annual Out of the Darkness walks to raise funds for suicide prevention, education, and research.[4] However, funding for suicide prevention efforts continues to lag behind its importance as a leading cause of death.

Can suicide be prevented? Lithium treatment for bipolar illness is clearly associated with decreased suicide completion. Short-term interventions with high-risk teens have improved coping skills, enhanced self-esteem, and reduced depression. Data about the long-term effectiveness of suicide prevention programs are lacking. Unfortunately, if an individual wants to commit suicide, it can be almost impossible to keep them from succeeding. Parents of teens who committed suicide agonize over whether they should have had their teen hospitalized. My son had been in the hospital only 6 days before he died. This self-doubt about whether we could have done anything is part of the grief that we share. It does not mean, however, that we should sit back and do nothing.

There are steps we must take. Pediatricians should learn the signs of depression and take all threats of suicide seriously. We must advocate for our patients to get appropriate mental health services, including counseling and the judicious use of medications. We must offer our services to discuss with parents their feelings and guilt about teens who are struggling. We need to talk to teens frankly, value them as persons, and respect their feelings as important. When a youth dies by suicide, we need to be supportive for the parents and family. The bonds that are formed at that time will cement your relationship forever. And finally, we should be available to colleagues who are grieving. I know that my colleagues have been there for me and given me strength to move ahead.

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