Source: *The Straits Times,* pA21
Date: 10 September 2021

Suicide survivors and lessons from a troubled life

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PHOTO: AGENCE FRANCE-PRESSE

On Sept 10 each year, the world marks Suicide Prevention Day. In the search for ways to prevent more tragic deaths, researchers embark on a heartbreaking journey with family members of suicide victims to find out the possible reasons for why they chose to end their lives.

Chong Siow Ann
For The Straits Times

"I thought then that today is the day I want to end it," she told me.

"It" was her life, and she was my patient. Hers was a long illness, with origins in childhood history of trauma and neglect, with the abandonment of father and sexual abuse by a stepfather, of scarified arms from self-cutting, of wreckage of relationships, and multiple hospitalisations.

She made that statement to me after she was brought to the hospital by the police – and after they had coaxed her away from the narrow ledge outside her flat on the 10th floor.

She had also told me previously that her present life was empty, as would be her future. But it was not just emptiness, it was more of a negation – she had envisioned her future as one devoid of any real happiness, of separation from family members, of the inability to work and form meaningful relationships, and of the dissolution of friendships.

She saw a life of abject loneliness and deterioration, repeated forced admission to the Institute of Mental Health, and marginalisation from society. Irretrievably sad, she thought of suicide as the only option.

When I became a psychiatrist, I would be asked at various times by different people with genuine curiosity why I had chosen this profession. I used to have some problem coming up with a satisfactory response without sounding trite or pompous.

The usual answer I would give, and which I also think is largely true, is that most of us became psychiatrists because we want to work in that nebulous zone where the human brain and mind intersect. But more particularly, we want to understand the human mind and spirit, and the ways that they can be broken, and how we can ease the pain and suffering.

Although some pathological patterns generalise across individuals, no two patients are identical. This is what makes psychiatry challenging and at times wrenching, as we often care for people who suffer immensely and for whom we wish we could offer even more help, while resisting letting their misery and despair drag us to a state of helplessness. And this is even more so for patients who are determinately suicidal.

Every psychiatrist is conversant with the risk factors for suicide that have been identified by a large body of research: genetic predisposition, impulsive and aggressive personality traits, traumatic events in the early years of life, alcohol dependence, use of illicit drugs, psychological crises, mental illnesses like depression and schizophrenia, social isolation, and loneliness.

But it is impossible to prevent all suicides. One standard textbook of psychiatry has rather pessimistically if defensively stated that suicide is to the psychiatrist what cancer is to the internist – the doctor may provide optimal care and yet the patient still dies.

CEMETERY OF PATIENTS

The neurosurgeon Henry Marsh wrote in his book, Do No Harm, that surgeons have a cemetery of their dead patients which they carry within themselves. I would say that psychiatrists similarly have such cemeteries within themselves of their patients who died by suicide.

Interred in my memory are the headstones of my patients which, if I allowed myself, I could summon up without much effort – their faces, their manner of death, and the painful conversations that I had with their families in the aftermath of their suicide.

Losing patients this way is always a bitter pill to swallow. I might have become a bit more resilient with a tougher carapace from years of experience, but I have also become more realistic of the limitations of psychiatry and the unpredictability of people.

And though I am now less anxious about how I might be judged by my peers, that sense of failure and culpability is always there and becomes even stronger as I face their families – a tension that is compounded by the dread of not knowing what to expect.

Still, I would always try to meet them. To be honest, there is this sordid desire to placate grieving and angry relatives who might complain and sue. But largely, I would meet them because I know there are questions that they would want to ask, and there would be questions that I want to ask of them; and it is also simply the right and decent thing to do.

In all these meetings that I have had so far, there had been no animosity or recrimination towards me – only once did a patient's sister angrily interrogate me. The families or close friends who were most affected, and whom we called survivors, would have already spent a great deal of time examining their relationship with the decedent – turning it over and over and looking at it from many perspectives for clues of what could have gone wrong.

Psychologist Edwin Shneidman, founder of the American Association of Suicidology, a non-profit association dedicated to the understanding and prevention of suicide, said that "the person who commits suicide puts his psychological skeleton in the survivor's emotional closet" and leaves the survivor to deal with "many negative feelings and, more, to become obsessed with thoughts regarding his own actual or possible role in having precipitated the suicidal act or having failed to abort it".

Almost inevitably, these survivors would blame themselves for not knowing or doing more, and would agonise over what they could have done differently.

Most of the meetings that I have had with the survivors were halting and long. I had learnt to suppress that anxious urge to talk too much, and to wait instead for the questions to come and to answer them straightforwardly and honestly, and I would also ask my questions.

But we would almost always emerge no wiser as to the actual reason for the suicide. I would try to do what I could to help and console the survivors, tell them to look out for signs of prolonged depression and offer further assistance if necessary.

But I would come away from these meetings disquieted, unedified and feeling desolate – partly because I could not change anything when I do not know what has gone wrong. I worried about when the next suicide would happen among my patients because I have not learnt.

PSYCHOLOGICAL AUTOPSY

But I have always believed that good research will enable us to help our patients. This is why I am now part of a study recently initiated by my colleague, Associate Professor Mythily Subramaniam, and funded by the Ministry of Health.

This study uses an approach called psychological autopsy developed by the late Dr Shneidman, and is a method of inquiry using a structured questionnaire to elucidate the factors that could have led to a person's suicide.

Alongside any documents about the decedent, interviews are conducted with family, friends and associates. Beyond identifying basic information about the decedent and details of the death, personality, lifestyle, interpersonal relationships, medical illnesses, medical treatment, previous suicide attempts, the inquiry also focuses on any recent history of stresses, possible triggers, and relevant thoughts relating to suicide that the individual might have expressed.

"From these diverse pieces of information, a biographical narrative is constructed from which a more profound and nuanced understanding of the individual and the circumstances leading to the suicide would be formed," explained Prof Subramaniam.

I have done a few of these lengthy and demanding interviews, which are different from those conversations with survivors of my patients who have committed suicide, where there is always that deep personal involvement with its own sadness.

But it is still difficult to stay the rational and dispassionate researcher when conducting the psychological autopsy – I feel the buffeting waves of grief, bafflement, pain and, at times, anger that emanate from those survivors who have volunteered to help us. And throughout these recursive but fraught and sometimes tangled interviews, there was that undercurrent of a floundering search for answers.

I know we risk inflicting more pain when we carry out these interviews, but I hope that in those couple of hours, these survivors had felt the sense of kinship of being fellow seekers, and that beyond being cathartic, the interviews had helped them, in some ways, to come to a better understanding – if not acceptance – of their loss.

But there are many paths to that fateful and fatal decision, and we need many more survivors to help us construct these narratives. For it will be from the knowledge that can be gleaned from these heart-breaking testaments that will give us the hope and means of preventing more suicides.

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Helplines

• National Care Hotline: 1800-202-6868 (8am to midnight)

MENTAL WELL-BEING

• Institute of Mental Health's Mental Health Helpline: 6389-2222 (24 hours)
• Samaritans of Singapore: 1800-221-4444 (24 hours) /1-767 (24 hours)
• Singapore Association for Mental Health: 1800-283-7019
• Silver Ribbon Singapore: 6386-1928
• Tinkle Friend: 1800-274-4788
• Community Health Assessment Team: 6493-6500/1

COUNSELLING

• TOUCHline (Counselling): 1800-377-2252
• TOUCH Care Line (for seniors, caregivers): 6804-6555
• Care Corner Counselling Centre: 1800-353-5800

ONLINE RESOURCES

• mindline.sg
• stayprepared.sg/mymentalhealth
• eC2.sg
• www.tinklefriend.sg
• www.chat.mentalhealth.sg

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