Experience

Expérience

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In November 1992 Dr. Arthur Sommer Rotenberg, a well-respected family physician in Toronto, took his own life at the age of 36. He was remembered by a friend for living life "with brio; that is, with intensity, purpose, passion for romance, adventure and, most of all, compassionate communication." To honour the memory of her son, Mrs. Doris Sommer-Rotenberg initiated the endowment of a chair at the University of Toronto for the study of suicide. In January 1997, Dr. Links assumed the newly created Arthur Sommer Rotenberg Chair in Suicide Studies, the ultimate purpose of which is "to reduce the losses and suffering from suicide and suicidal behaviours." This program is the only one of its kind in North America.

Suicide and life: the ultimate juxtaposition

Paul S. Links, MD

More than 3500 Canadians will kill themselves this year, and for every suicide an estimated 100 attempts will occur. Adolescent suicide has increased 4-fold since the 1960s, and Canada now has one of the highest rates of youth suicide in the industrialized world.

As others have observed, the suicidal person is ambivalent;[1] a passion for life often coexists with despair. Three experiences from my clinical practice helped me to appreciate this fact by demonstrating the great strength as well as the fragility of the human spirit.

The first patient I will describe overdosed on my prescription. He spoke to me afterward of his determination to die, his consumption of a case of beer to liquefy his last inhibitions, his carefully planned solitude and his declaration of remorse, sent by email to his family. He was certain that swallowing his entire supply of medication would be lethal. However, his gastrointestinal tract proved to be a determined adversary against dissolution: he became wretchedly ill and was unable to keep the pills down. Defeated, he told his lover what he had done and went to the emergency department.

I felt an amalgam of emotions as I listened to his story. Certainly, I was relieved that he had survived and was sitting before me in his usual chair, as he had twice weekly for the last 3 years. But I was also angry and hurt. Why had he not revealed his desperation that night? How would my prescription of weeks' worth of medication have been viewed if an inquest had been called? What had I missed from our last session? My guilt and anger alternated like the flashing sides of a rotating roadway sign.

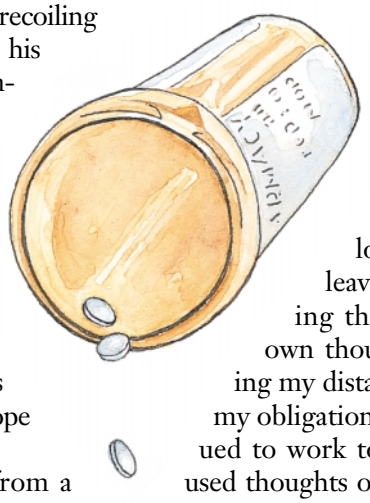
My patient read me well and encouraged my self-disclosure. I shared my immediate feelings and looked for his response. He understood and identified with my emotional turmoil. He somehow drew a resolve to continue his life from his failed attempt to end it. Maybe, I suggested, the addition of an antidepressant might be the answer. He expressed his willingness to try anything. His hope emerged before me like a prizefighter pushing up from the canvas.

This renewal made me realize that I myself had been drowning in the sea of hopelessness that my patient brought to me twice weekly. This hopelessness had seemed justified. My patient's mental illness had destroyed his career and torn his marriage apart; during the divorce his diagnosis had been hurled at him like a medieval weapon, and he was left with only limited access to his children. I had adopted his feelings of futility. In my effort to help, I had taken on his hopelessness, and this had left him feeling helpless in return. Surviving the suicide attempt rekindled his belief that he could endure.

The second experience involved a married couple who were referred to me by their family physician after the wife had expressed suicidal feelings. She was an engaging businesswoman who felt that everyone found her attractive except her husband. He had an imposing physical presence but kept himself carefully distant from his wife as they settled themselves into the office for the first visit. They revealed a history of bitter arguments. The husband was committed to the belief that his wife was reckless and would take them to bankruptcy. The wife was equally convinced that her husband was concerned only with his career and felt passionless toward her, leaving her feeling hopeless and close to suicide. I ob-

served her persistence at trying to draw out her husband, and how this was matched by his determination to avoid emotional conflict.

I sought to undermine their standoff. Instinctively, I went after the hulking man who cowered against the arm of the couch. I pushed him to talk about his desperate insecurity and his fear of losing his wife. He confessed that he did not know how to approach her without recoiling at the first sign of emotion. He agreed that his emotional withdrawal was his attempt at damage control, for the last thing he wanted was to lose his family. His tears, his risk of expression and his need for security touched his wife. I left the session feeling that there had been a real breakthrough for this couple. They had reversed the destruction of their marriage by connecting with their need for human attachments. Human bonds can move us from anguish and the brink of suicide to hope for renewed happiness.



My third lesson came, paradoxically, from a highly suicidal patient who was seeing me for psychotherapy. Her towering medical record told of repeated overdoses, some of which were life threatening, and most of which were not. In the early years of her therapy she had spent many hours talking about her suicidal thoughts and wishes. She described her childhood: her parents had struggled for their own survival, and her mother was left to care for the children when her father was incarcerated for a violent crime. The children were often left unsupervised. Through years of abuse, her brothers devoured her will like a pack of hounds. Acknowledging her survival, she credited a brief intense relationship as her only reason to hope for a better future. Her only sense of worth came from her intelligence and her vocational success.

I had learned to respect this patient's need to discuss suicide as an option. Early in our relationship, suicidal threats were one of the few modes of communication she could manage. But I remember one hectic day during her second year of therapy when she ended our session with a haunting threat not to return. It was not until she had left that it sank in. I sat feeling as if I had been jolted from a deep slumber by a loud, shattering scream. What had happened here today, I wondered? I dealt with my uncertainty by sending the police out to find her. A long evening with my patient in the emergency department allowed me to reflect on the manner of her leaving at the end of our last meeting. During the session I had been embroiled in my own thoughts and preoccupations. Clearly sensing my distance, she shook me back to reality and to my obligation to her and to the therapy. As we continued to work together, I came to understand how she used thoughts of death to cope with life. In her life, she felt herself to be powerless. By considering death, she could empower herself by making the ultimate choice and, in so doing, take control of her life.

Hope and despair, anguish and renewal often exist side by side as patients in crisis maintain a precarious balance between suicidal impulses and the affirmation of life. It is critical that physicians appreciate the importance of their role in recognizing and helping to alleviate suicidal feelings in their patients. Above all, they must sustain the belief that hope can be reactivated from the depths of despair.

Reference

1. Leenaars AA. Suicide: a multidimensional malaise. *Suicide Life Threat Behav* 1996;26:221-36.