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EMSWORLD

BY CHRIS G. CAULKINS, MPH, FF, EMT-P ON FEB 9, 2010

Like many of you, I am a paramedic and a firefighter. The thing that may set me apart is that I am also a suicide survivor; a person in a club no one wants to join. I would like to take this opportunity to help you, my peers, understand the nature of mental illness and suicide.

My life has changed completely—twice. The first change came after the death of my wife, Mary, on March 5, 2003, and the second came on October 15, 2008, after the death of my 27-year-old brother, Jeremy. The cause of both Mary's and Jeremy's deaths was severe depression that resulted in suicide.

With Mary, our family could see the runaway train of mental illness coming down the tracks and could do nothing about it in spite of our best efforts. Mary was on six medications at the time of her death, had received in-patient and out-patient care, read self-help books avidly, sought religious counsel, tried meditation and breath work, was a member of a peer support group, went through electroconvulsive therapy, and was attended to regularly by her psychologist, psychiatrist and social worker. Every time Mary was hospitalized, her friends and family rallied to support her with telephone calls and visits to the behavioral health unit. We loved Mary and she knew it.

Jeremy was a different story. Although my family was aware of anxiety and depression issues, we had no idea as to the depths of his despair. Later, I learned from Jeremy's journal that he felt he was somehow morally flawed and "less of a man" because of his disease. Because of these beliefs, he kept the extent of his illness from the very family and friends who loved him and would have offered help. Instead, Jeremy kept his pain to himself and drank alcohol until he passed out every night, just so he could get to sleep. According to the National Alliance on Mental Illness, it is estimated that 29% of people diagnosed with a mental illness abuse either alcohol or drugs.

Mary succumbed to her illness early one cold March morning in the back seat of her van in a parking lot of an apartment complex not more than two miles from our home. In spite of great pains taken by her social worker to ration her medications, she managed to fatally overdose on them.

Unbelievably, Jeremy succumbed to his illness early on an October morning five years after Mary. Jeremy ingested several cans of beer, as was his practice, but this day was different. Instead of passing out in an intoxicated sleep, he shot himself in the head with a handgun, leaving his roommate to discover his body. I'll never forget the sound of my mother's pained voice on the telephone that morning. I was shocked that this type of tragedy could befall my family not only once, but twice. I often feel as though everything is surrealistic--like I'm walking around in a Salvador Dali painting. I'm honestly

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afraid it could happen again.

Mary was many things to many people: wife, mother, daughter, sister, grandchild, niece, friend and dog mommy, to name a few. She was an avid outdoor person and worked as a physical therapist.

Jeremy was a brother, son, grandson, nephew and friend. He was an executive chef at a country club and was in college working toward becoming a law enforcement officer. Jeremy was the life of the party and a self-proclaimed "mommy's boy."

Understanding Mental Illness

According to the Centers for Disease Control and Prevention (CDC), suicide is the 11th-leading cause of death overall, the No. 2 cause for the age 10-24 group, and the third-leading cause of death in the 24-35 age group. It is said that each suicide affects at least six other people. In my estimation, this is a gross understatement.

My purpose here is to give Mary's and Jeremy's lives meaning by helping other people with this affliction. To do this, you must be willing to enhance your understanding of and response to psychological emergencies as I convey three messages: 1) the nature of mental illness; 2) taking away the stigma; and 3) helping the survivors if the unthinkable occurs. Notice that care of the patient has been omitted. This is because items one and two will help tremendously with care, and because you are already very competent in the technical response to virtually any emergency.

Society as a whole fails to recognize mental illness for what it really is: a disease of the brain caused by neurotransmitter (monoamine) deficiency that results in behavioral symptoms. Mary and Jeremy died of a disease as surely as others have died of a heart attack or cancer, but because the signs and symptoms are largely more behavioral than physical, it is often not viewed in the same light. This is evident in the lack of parity in treating these diseases. In other words, we do not devote the equal time, resources, funds or even healthcare reimbursement for mental illness as we do for diseases of other body systems. Yet many of

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these illnesses are highly treatable if recognized.
Mary's case of refractory depression seems to be an extreme exception, but I believe Jeremy could have been helped.

The lack of parity is a good segue into the second message: removing the stigma. It is because of the fundamental misunderstanding of this disease process and the resulting stigma that there is no parity. The stigma is also perpetuated by the societal view of mental illness, which has advocated for many years that we hide the problem, discriminate against and disassociate ourselves from these patients, and generally write them off as "nut cases." How many times have you been dispatched to a "psych call" and heard your partner pine for a "real" call or complain about having to go on a "BS" run? I am embarrassed to admit that I have both heard it and said it many times. I had to learn the hard way by having this happen to people I love. No longer is it just another psych call when a person in my care has the same scared look and mannerisms my wife displayed. Worse yet, I have had partners who delighted in verbally poking and prodding the behaviorally unstable patient to the point of his acting out physically in the hopes of a good tussle. One time, my partner provoked our patient so much that the police had to meet us at the hospital to get him out of the ambulance. I was not as strong then as I am today, so I said nothing, silently hoping my partner would learn his lesson. I would never tolerate that behavior from a coworker now. I challenge you to be intolerant of this type of behavior from your peers. How would you feel if your mother, brother or child were treated in this manner? I wonder if anyone would provoke an agitated hypoxic patient for fun. Someone somewhere loves that person, and you are entrusted with their care as you are with any other type of patient.

I think you will find that incorporating my first two messages will greatly enhance your care and understanding of the patient with a mental illness. Unfortunately, as in Mary's case, this is not always enough. Please remember that if you respond to someone who has attempted or died by suicide, there are other people who need care--the family members. This illness is taxing emotionally and perhaps even physically or financially. I remember my sheer exhaustion from taking care of someone who cried inconsolably for hours or laid in bed for days at a time. I lived in constant fear that I would come home from work and find Mary dead. Sometimes my mother would stand watch and help bathe and feed my adult wife. We had ambulance, clinic, pharmacy and hospital bills to copay, and my 5-year-old daughter wondered aloud if mommy would ever get better. When Mary died, I felt like I was the only person in the world this had ever happened to. I had no idea what resources were available or how to seek help for myself or my daughter.

Making a Difference

Since Mary's and Jeremy's deaths, I have learned that I am absolutely not alone and the resources are out there to help. An acquaintance of mine who lost her son to depression has developed a pamphlet for first responder and EMS personnel to

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give out in the event of a suicide attempt or death. It explains what depression is, facts about suicide, resources for help and further information. We have successfully placed these with several agencies, and they have been used with a desirable effect. A former employer of mine also has a brochure titled *When a Loved One Dies*, which is an invaluable resource for those who are left behind after any death and includes information on making funeral arrangements, financial issues, etc. Together, these documents are a wealth of information for those in need.

Other ways to make a difference in the lives of the survivors includes giving them access to the body as soon as practical. Everyone grieves in different ways, and this can be vitally important to some people. In my support groups, I hear story after story of distraught family members who were not allowed to see their loved one's body. Most of them were told that they simply were not allowed to, or that it was a "professional" recommendation that they not see the body. This has been relayed not only by EMS personnel, but by hospital staff, law enforcement and even the medical examiner. I understand the need to investigate the death and gather potential evidence, but there is a balance that can be struck to accommodate the family.

Many responders and medical personnel will dissuade the family with the good intention of sparing them the sight of their loved one in a less-than-desirable state of appearance, but this may not truly be serving the best interest of the survivor. I vividly recall having to press the issue to see and touch my wife and brother one last time. I do not regret it one bit, in spite of the fact that Mary was not found for almost two weeks and that Jeremy had a gunshot wound to the head. Some people will not want to see the body, and that is OK. I would submit to you that our job is to relay the options objectively and to inform the family in the best way possible about the condition of the body. Perhaps they only want to see and touch a hand or look for a birthmark or tattoo to satisfy their need for closure. The choice should be theirs; we are the nonjudgmental facilitators.

In conclusion, it is my sincere hope that my family's story will make a difference in the way you approach and care for those with mental illnesses of all varieties. Through understanding, removing the stigma of this disease process and helping those left behind, if necessary, you can truly make a difference in the lives of many people. And please don't forget to take care of yourselves and your families. I've learned to appreciate and enjoy what I have in the here and now.

Information about suicide is available from the American Association of Suicidology (www.suicidology.org), the American Foundation for Suicide Prevention (www.afsp.org), the National Alliance on Mental Illness (www.nami.org) and the Suicide Awareness Voices of Education (www.save.org). Specific information for emergency responders is offered by the Suicide Prevention Resource Center (www.sprc.org). A recommended text is Thomas Joiner's Why People Die of Suicide *(2005).*

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